CHAPTER - I

Introduction
Non-communicable diseases are fast replacing infectious diseases and malnutrition as the leading cause of disability and premature death in developing countries. In the developing countries, out of a little more than 39 million deaths, which occurred in 1993, more than 10 million were caused by major non communicable diseases (WHO).

Hypertension and bronchial asthma are most prevalent and life threatening disorders in the developing countries. The role of various psychological factors like religiosity, ego strength, social support on subjective well-being among hypertension and bronchial asthma patients has been examined in this study. It is therefore, important to understand the nature and causation of these diseases.

**Bronchial Asthma**

The close relationship between respiratory function and psychological factors is well known. The combined voluntary and involuntary control of breathing allows close involvement with psychological factors. From birth onwards, respiration is intimately involved in communicating with others and expressing emotions. Laughter, crying, sighing, anger, fear are expressed through variation in respiratory rate and depth.

Asthma affects millions of Indians. Asthma is a common clinical problem and one of the common causes of hospitalization.
in developing countries like India. The worldwide prevalence of asthma as well as its morbidity and mortality is still rising. The prevalence rates range from 0.2% and 25% with an estimated incidence between 2-5 cases per 1000 per year among all age groups. The familial nature of asthma was first recognised by Maimonides in the 12th century. Asthma and allergy are linked to genetic predisposition, environmental exposure to common allergens, respiratory infections and pollution. In Delhi, Mumbai, Calcutta, Bangalore, the mega cities of India, prevalence of asthma is more. Probably climate, environmental exposures, urbanization, changes in multiple social lifestyle and dietary factors may play an important role in rising asthma prevalence. The word asthma is of Greek derivation and it means 'panting or gasping'.

In 1991 the National Asthma Education Program Expert Panel report from the National Institute of Health defined Asthma as "a lung disease with the following characteristics:

1. Airway obstruction that is reversible, either spontaneously or with treatment.
2. Airway inflammation.
3. Increased airway responsiveness to a variety of stimuli.

According to Shivpuri (1971) bronchial asthma may be defined as a disease characterized by recurrent expiratory dyspnoea due to
wide spread narrowing of peripheral airways in the lungs and not due to any known specific infection or infestation or organic lesion. It is further characterized by a hyper-reactive bronchial tree and varies in severity over a short period of time either spontaneously or as a result of treatment.

- Every year, Mumbaiites lose 20.2 million workdays to pollution related illness.
- 9.01 lakh people suffer from pollution related asthma
- 5,800 people are admitted to hospital for pollution related respiratory symptoms.
- 24,000 adults and 2.20 lakh children are affected by Chronic bronchitis caused by pollution.

(Source: National Environmental Engineering Research Institute)

Asthma can be defined as a chronic inflammatory disease of airways that is characterized by increased responsiveness of the tracheobronchial tree to a multiplicity of stimuli. Asthma attacks all age groups but often starts in childhood. In an individual asthma attacks may occur from hour to hour and day to day. In an attack, the lining of the passages swell causing the airways to narrow and reducing the flow of air in and out of the lungs.

Risk Factors

Asthma cannot be cured but could be controlled. The strongest risk factors for asthma are exposure, especially in
infancy, to indoor allergens and a family history of asthma or allergy. A study in the South Atlantic island of Tristan da Cunha, where in 3 of the 300 inhabitants has asthma, found that children with asthmatic parents were much more likely to develop the condition. Exposure to tobacco smoke and exposure to chemical irritants in the workplace are other risk factors for developing asthma.

Urbanization appears to be correlated with an increase in asthma. Experts are struggling to understand why rate of asthma is rising worldwide 50% every decade.

One such incident in London, U.K. in June 1994 saw 640 people rushed to emergency departments in the throes of full-blown asthma attacks. The World Health Organization recognizes asthma as a disease of major public health importance and plays an important role in the coordination of international efforts against the disease.

A series of cases have been reported showing a high incidence of emotional factors (Halliday, 1937, Mc Dermolt & Cobb, 1939), including some cases in which psychological stresses have been said to precede the appearance of the first attack of asthma.

Systematic studies of French and Alexander (1941), attempted to establish a specific psychological basis in asthma.
These investigators and their coworkers at the Chicago Psychoanalytic institute studied 27 patients who were suffering from both allergic asthma and emotional difficulties. They concluded that asthmatics show a specific psychogenic predisposing factor in the form of maternal over-dependency, with an exaggerated fear of losing maternal love & protection.

**Age:** Asthma and airways responsiveness are increased in very young and a very old individuals, individuals at the extremes of age have lower levels of lung function, such that milder degrees of airway inflammation and smaller changes in lung function may precipitate symptoms and hence, the diagnosis of Asthma.

**Gender:** Asthma in childhood is predominantly a male disease until puberty, following puberty asthma incidence is greater in females.

**Race:** Asthma prevalence is higher in blacks than in Whites.

**Socio-economic Status:** Lower socio-economic status is associated with an increase in asthma prevalence. This is due to indoor air pollution, maternal cigarette smoking, allergen exposure and decreased access to medical care.

**Young Maternal Age:** Some reports in literature suggest that infants born to mothers who are very young (i.e. less than 20 years) have an increased incidence of asthma.

**Prematurity** – Infants born prematurely carry a 4 fold increased
risk of development of asthma.

**Respiratory illness** – studies have demonstrated a prominent association between lower respiratory tract viral infections in early life and wheezing illness. Viruses are the precipitants of an even higher percentage of severe asthmatic exacerbation.

**Smoking:** Smoking has been associated with airway hyperresponsiveness in a number of population survey (Burney et al., 1987) as well as in many clinical studies. Smoking causes temporary increase in airway responsiveness in normal people. Several studies have reported a higher prevalence of asthma in children of smoking parents.

**Air Pollution:** Pollution could play an important role in asthma pollutant levels as a strong determinant of asthma (Department of Health, 1995b) Air pollution is unlikely to be the main driving force behind the recent increase in prevalence of asthma.

**Genetic Factors:** Asthma and allergy have long been recognized to have a familial basis. In a paper published in 1916, Cooke and Vanderveer studied family histories of 504 patients with allergy and concluded that inheritance is a definite factor in human sensitization.

**Psychological Factors:** A wide range of emotional situation may provoke asthma-anxiety, depression, guilt, anger, frustration, pleasure etc. Asthmatics are generally nervous and hyper-irritable.
Cattel's 16 PF personality profile studies and Rosenzweig picture frustration studies showed that asthmatics have suppressed aggression and guilt more than normals. Any unpalatable situation (emotional or psychological) may provoke an attack in them. According to Thomas Willis (1672) emotion could bring an attack of asthma. Rees found that when compared with a control group of surgical patients, asthmatics patients had a significantly higher prevalence of anxiety, timidity, sensitiveness and obsessional traits and neurotic symptoms. He found that the psychological status of the patients antedated the onset of asthma. Houston, Joiner, and Trounce (1966) have given the following statement: “Psychological influences play some important part in nearly every asthmatics and quite often they appear to be mainly responsible, if not in starting the asthma, atleast in maintaining it”. Anxiety of various kinds, a sense of frustration, or frequency discord, and an atmosphere of tension in home, often underlie the tension in the bronchi. Treatment is not likely to be satisfactory unless these influences are appreciated and the patients handled with sympathetic understanding, tact and firmness, and the difficulties eased as much as possible.

In most recent studies adverse psychological factors have been found in between 60% and 86% of asthma deaths, and in 88% and 89% of those with near fatal asthma. Most of the patients have
experienced more than one adverse psychological and/or social factors like depression, psychiatric history in a first degree relative, social isolation, marital problem, smoking, unemployment etc.

CLASSIFICATION OF ASTHMA

1. Persistent Asthma A patient with symptoms of asthma whose airway function is abnormal between attacks. The abnormal function can often be reversed.

2. Episodic Asthma A patient whose airway function is normal between attacks. Episodic asthma is more common in children than adults, and occurs in patients who are allergic to pollens and grain dusts during the season of exposure.

3. Occupational Asthma Occupational asthma is uncommon, but it is important to recognize patients with this disease at an early stage, because it is potentially reversible. Usually, it is episodic at first, but becomes persistent.

Classification Of Asthma Severity

Mild Asthma Discrete attacks for no more than 1-2 days occurring no more often than one per month, with very brief attacks.

Moderate Asthma Attacks occurs more often than twice weekly with occasional more prolonged exacerbations and requiring frequent or daily medication for relief of symptoms.

Severe Asthma Continuous symptoms with occasional prolonged
severe exacerbation and required daily medication. Mild and moderate asthma may be seasonal. Severe asthma is rarely seasonal although the severity of symptoms and need for treatment may fluctuate from time to time.

There are two other forms of asthma which do not fit in above classification but are seen from time to time occurs in patients.

1. Exercise Induced Asthma (EIA) Exercise is a potent stimulus for a short attack of bronchospasm and occurs in most asthmatics if they exercise hard enough.

2. Sudden life-threatening Asthma A few asthmatics suffer from infrequent but devastatingly severe attacks of asthma often the onset of an attack is unpredictable.

PREVALENCE:
Asthma is a common disease with an overall prevalence in the general population on of 6-7 %. A higher prevalence of the disease is found in the elderly. It is estimated that 7-9% of the individuals over the age of 70 has asthma.

The prevalence of asthma and allergic continues to increase practically everywhere in the world. India has an estimated 15-20 million asthmatics.

The multi center European community respiratory health survey, in Mumbai interviewed 2313 adults about asthma symptom's,
diagnosis, and medications they have taken in the previous 12 months in the second phase of the study, the researchers gathered more detailed information about smoking histories, housing characteristics, serum IgE levels, and results from skin tests with nine allergens. According to them, the asthma prevalence was 17% compared with 3.5% by physician diagnosis.

Another study was carried out on bank employees in 4 centres of Vellore town. The prevalence of self reported bronchial asthma was 8.3% that of asthma related symptoms 15.8%. There was a significant association between those who have symptoms of asthma and a positive family history of asthma.

Prevalence of asthma was calculated among adults in North India, using a Hindi adaptation of the International Union Against Tuberculosis and Lung Diseases (IUATLD) 1984 Questionnaire. True population prevalence calculated from the observed prevalence using specificity and sensitivity of the questionnaire was 3.94% in urban men, 3.99% in rural men, and 1.27% in both urban and rural women (Jindal et.al, 2000).

According to new worldwide survey which covered 140,000 persons aged between 20 and 44 in European union countries and Iceland, Estonia, Switzerland, Algeria, India, Newzealand, Australia and the USA. The main cause of asthma was found to be due to environmental factor and allergens. The prevalence can
vary by a factor of 1 to 6 from one country to another.

The ECRHS is the first study to access the geographical variation of asthma and allergic diseases in a large number of countries. First they used identical standardized protocol for all the different areas.

Second they combined subjective and objective measurement, the good thing is that both approaches indicates the same, quite marked pattern of geographical variation in asthma and allergic diseases.

Asthma is not just a public health problem for developed countries. In developing countries, however, the incidence of the disease varies greatly.

- India has an estimated 15-20 million asthmatics.
- In the western pacific region of WHO, the incidence varies from over 50% among children in the caroline islands to virtually zero in Papua New Guinea.
- In India, rough estimates indicate a prevalence of between 10% to 15% in 5-11 year old children.

**The human and Economic burden.**

Mortality due to asthma is not comparable in size to the day-to-day effects of the disease. Although asthma is avoidable, but is found to occur in epidemics and affects young people.

- World wide, the economic costs associated with asthma are
estimated to exceed those of TB and HIV/AIDS combined.

- In the United States, for example, annual asthma care costs (direct & indirect) exceed US $6 billion.
- In Australia, annual direct and indirect medical costs associated with asthma reach almost US$460 million.

Janmeja (2002) said more than 150 million people in the world are suffering from asthma. In developed countries about 10% of the population has asthma. In India 2 to 5% population has this disease, while the incidence is around 10 to 15% in children.

**Hypertensive Heart Disease:**

In many developed, countries hypertension is the commonest cardiovascular problem and developing countries are also facing this problem. Hypertension is a disorder that is characterized by high blood pressure, generally this includes systolic blood pressure (the “top” number of your blood pressure measurement, which represents the pressure generated when the heart beats) consistently higher than 140, or diastolic blood pressure (The “bottom” number of your blood pressure measurements, which represent the pressure in the vessels when the heart is at rest) Consistently over 90.

Hypertension is an “iceberg” disease. It is a major public health problem in our society and the cause of countless cases of stroke, myocardial infarction, congestive heart failure, renal
failure and peripheral vascular disease. As the U.S. population ages, the incidence of hypertension increase as well, nearly 50% of people aged 65 and older have high blood pressure (i.e. systolic-140 mm Hg diastolic –90 mm Hg). Yet many of them are not aware of the problem.

The National Health and Nutrition Examination survey III conducted between 1991 and 1994, showed that only 68% of patients with Blood pressure values above 140/90, know they had hypertension, and only 55% were being treated. The patient at greatest risk for the consequences of high blood pressure are the elderly, many of whom have a form of hypertension known as isolated systolic hypertension.

**Classification of Hypertension**

Clinically, hypertensive individuals are characterized according to the severity of their illness on the basis of either diastolic or systolic blood pressure. The precise cut-off points are arbitrary and vary between different classification systems but generally WHO classification (1978) depends on diastolic blood pressure level.

1. Mild-diastolic pressure 95-110 mm Hg
2. Moderate 111-120 mm Hg
3. Severe 125 mm Hg.
Sixth joint National committee criteria (1997) Classification of blood pressure for adults 18 years and older-

<table>
<thead>
<tr>
<th>Category</th>
<th>Systolic BP (mmHg)</th>
<th>Diastolic BP (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal</td>
<td>Less than 120</td>
<td>Less than 80</td>
</tr>
<tr>
<td>Normal</td>
<td>Less than 130</td>
<td>Less than 85</td>
</tr>
<tr>
<td>High normal</td>
<td>130 – 139</td>
<td>85 – 89</td>
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<tr>
<td>Stage 1 Hypertension</td>
<td>140 – 159</td>
<td>90 – 99</td>
</tr>
<tr>
<td>Stage 2 Hypertension</td>
<td>160 – 179</td>
<td>100 – 109</td>
</tr>
<tr>
<td>Stage 3 Hypertension</td>
<td>180 – and above</td>
<td>110 and above</td>
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Hypertension is generally divided into 2 broad groups.

1. **Primary or essential hypertension:** Hypertension is classified as "essential" when the causes are generally unknown. Essential hypertension is the most prevalent form of hypertension accounting for 90% of all cases of hypertension. Two third of all cases of essential hypertension are in the 45-60 age group.

In the 1950s and 1960s, an important debate occurred between the British Physicians over the influence of heredity on high blood pressure in humans. Robert Platt argued that essential hypertension was a "qualitative" disease, controlled by a single gene, with a biomedical population distribution. George Pickering thought that hypertension was a "quantitative" disease and was controlled by multiple genes in combination with environmental factors.
influences. Today, both environmental and genetic factors are under intense study as possible etiologic factors at the individual level and the population level. Fortunately, however, successful efforts are being made to lower blood pressure through diet, stress reduction, exercise, weight control, and medication.

Causes of primary or essential hypertension are unknown but several factors seem to play a role that includes:

- Hyperactivity of sympathetic nervous system.
- Increased renin secretion.
- Expanded vascular volume.
- Excessive dietary intake of salt etc.

2. Secondary Hypertension

This accounts for less than 10-12% of all hypertension. It can occur at any age. Hypertension is classified “secondary” when some other diseases process or abnormality is involved in its causation (1) diseases of Kidney (Chronic glomerulnephritis and Chronic pyelonephritis and polyaystic disease, diabetic nephropathy, renal artery stenosis (ii) endocrinal diseases, cushings syndrome, tumours of adrenal glands (iii) cardiovascular diseases-congenital narrowing of aorta (iv) miscellaneous-toxemias of pregnancy, drugs, oral contraceptives containing destroying anabolic steroids, NSAID, Corticosteriod
carbenoxolone. According to clinical course both essential and secondary hypertension may be: (i) Benign and (ii) Malignant

(i) **Benign hypertension**: About 90-95% patients are benign hypertensive. It has moderate elevation of blood pressure which rises slowly as the years pass.

(ii) **Malignant hypertension**: Less than 50% hypertensive patients develop malignant hypertension. Malignant hypertension is marked with rapid increase of blood pressure to 200/140 mm Hg and has serious damaging effect.

Patient who have occasional blood pressure readings of over 150/90 mm Hg may very well be in an early phase of essential hypertension (Levy et al, 1944).

**Risk Factors:**

Hypertension is not only one of the major risk factors for most forms of cardiovascular diseases, but it is a condition with its own risk factors. A WHO scientific group has recently reviewed the risk factor for essential hypertension. These may be classified as:

**Non Modifiable Risk factors:**

(a) Age: Blood pressure rises with age in both sexes and the rise is greater in those with higher initial blood pressure. Age probably represents an accumulation of environmental influences and the effect of genetically programmed senescence in body systems.
(b) Genetic Factors: There is considerable evidence that blood pressure levels are determined in part by genetic factor. The evidence is based on twin and family studies. Twin studies have confirmed the importance of genetic factor in hypertension. Family studies have shown that the children of two normotensive parents have 3% possibility of developing hypertension, whereas this possibilities is 45% in children of two hypertensive parents. Blood pressure levels among first-degree adult relatives have also been noted to be statistically significant. Heredity plays an important role in cardiovascular illness, was suggested by Day and Day (1972). It has been observed that 40% issues are affected when both father and mother have hypertension whereas only 30% are affected while one of them is hypertensive.

**Modifiable Risk Factors:**

a) **Obesity:** Epidemiological observations have identified obesity as a risk factor for hypertension. The greater the weight gain, the greater the risk of blood pressure. Gupta et al., (1977) observed that with the increasing weight there is progressive rise in blood pressure.

b) **Salt Intake:** There is an evidence that a high salt intake (i.e; 7-8g per day) increases blood pressure. Low sodium intake has been found to lower blood pressure. For instance, higher incidence of hypertension is found in Japan where sodium intake is very high.
c) **Alcohol:** High alcohol intake is associated with an increased risk of high blood pressure. Habit of cigarette smoking affects human longevity adversely by several ways—notably by causing increase morbidity and mortality.

d) **Environmental Stress:** The term hypertension itself implies a disorder initiated by tension or stress. It is an accepted fact that psychosocial factors operate through mental processes, consciously or unconsciously produce hypertension.

Mathur et al (1963) and Celine (1970) found highest mean systolic and disystolic blood pressure in higher socio economics groups and lowest in low socio economic groups

**Others Factors:** Recent evidence suggests that saturated fat raises blood pressure as well as serum cholesterol. The commonest present cause of secondary hypertension is oral contraception, because of oestrogen component in combined preparations. Other factors such as noise, vibration, temperature and humidity require further investigation.

**PREVALENCE**

High blood pressure is a major contributor to the India's populations morbidity mortality and related cardiovascular diseases-stroke and renal insufficiency with the globalization and lifestyle changes that are now taking place in the region. Around 10-15% of the adult population is already affected by hypertension
The prevalence of hypertension depends on both the racial composition of the population studies and the criteria used to define the condition. In white suburban population like in the Framingham study nearly one fifth of the individuals have blood pressure >160/95 while almost one half have blood pressure >140/190.

An even higher prevalence has been documented in the non-white population. In female the prevalence is closely related to age, with a substantial increase during after age 50. The increase is presumably related to hormonal changes of menopause, although the mechanism is unclear. The ratio of hypertension frequency in women vs men increases from 0.6 to 0.7 at age 30 to 1.1 to 1.2 at age 65. The prevalence of various forms of secondary hypertension depends on the nature of the population studied and how extensive the evaluation is.

According to meta analysis the prevalence of hypertension among adults in India is 11%. There is an increasing trend in the prevalence of hypertension.

The incidence is more in urban than in rural population. In Karanatka hypertension was observed 1% among boys and 0.6% among girls. The prevalence of hypertension was 59.9 and 69.9 per 1000 in males and females respectively in the urban population
and 35.5 and 35.9 per 1000 in males and females respectively in the rural population (Gupta, 1997)

High blood pressure ranges from 4.3 to 12.1%. In a survey in progress in urban Delhi, a prevalence of 17.4% has been observed in person, aged 35-64 years (Using a threshold of 140/90 mm Hg) (Source-WHO, World Health Statistics Quarterly, 1993) Aggarwal (1992) observed a prevalence of hypertension as 37.8% in cardiovascular diseases cases in a study conducted in Jawan Block of District Aligarh.

A higher prevalence of hypertension in males was noticed by Chadha (1991) Aggrawal (1992), and Joshi et al., (1993), Goel and Kaur (1995) and Sharma and Singh (1997) observed a higher prevalence of hypertension in females.

It is well recognized that hypertension is now a major health problem in India. The various epidemiological studies published from India over the last decades are presented in a graphical form in fig 1 A review of this data shows that prevalence of hypertension has progressively increased over the last 5 decades, particularly in the urban areas the studies are not representative of the total Indian population, as these have been limited to singly centers. The fact that hypertension is a major health problem in our country calls for large, nationwide, multicentric, prospective and supervised epidemiological studies.
Fig. 1: Prevalence of Hypertension in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Prevalence (%)</th>
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<tbody>
<tr>
<td>1963</td>
<td>&gt;20</td>
</tr>
<tr>
<td>1978</td>
<td>&gt;20</td>
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<tr>
<td>1980</td>
<td>&gt;18</td>
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<tr>
<td>1984</td>
<td>(20-60)</td>
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<tr>
<td>1986</td>
<td>&gt;21</td>
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<td>1988</td>
<td>(22-60)</td>
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<td>1990</td>
<td>(25-64)</td>
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<tr>
<td>1995</td>
<td>&gt;20</td>
</tr>
<tr>
<td>2000</td>
<td>(28-65)</td>
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Source: Pfizer India: Indian Guidelines for Management of Hypertension
Singh (2002) said that according to a PGI study about 6 to 25% Punjabis are suffering from hypertension.

**Hypertension: A Burgeoning Burden in Poor Countries:**

By 2025 most elderly in the world will be living in developing countries, hypertension is one of the commonest diseases of the elderly, likely to pose a considerable burden on these countries. There were 600 million hypertensive in the world at risk for heart attack, stroke and cardiac failure, 180 million in the high income and 420 in the low middle-income countries.

A cross sectional community based survey, undertaken by the hypertension study group to determine the prevalence the hypertension among the elderly at two cities in Bangladesh and three in India, found that 65% of the 1203 elderly individuals surveyed had hypertension and only 45% were aware of the fact. Of the 40% hypertensive taken medication, only 10% were receiving adequate treatment. Hypertensive heart diseases are the leading cause of illness and death from hypertension. It affects approximately 7 out of 1000 people. 30 million people die annually from hypertension and other heart conditions.

The main aim of the present study is to examine the influence of religiosity, ego-strength, and social support on subjective well-being of the bronchial asthma and hypertensive patients. A brief account of each variables is given in the
SUBJECTIVE WELL-BEING

The term "subjective well being" (SWB) refers to people's evaluations of their lives. These evaluations include both cognitive judgments of life satisfaction and affective evaluations of moods and emotions. If a person reports that her life is satisfying, that she is experiencing frequent pleasant affect and that she is infrequently experiencing unpleasant affect, she is said to have high subjective well-being. Although life satisfaction, pleasant affect, and the lack of unpleasant affect often co-occur to some degree within the same individuals, these components are separable. Someone who experiences a great deal of pleasant affect, for example, may also experience very little unpleasant affect and be labeled "happy", whereas someone who experiences a high level of both pleasant and unpleasant affect may be labeled "highly emotional."

Subjective well-being especially life satisfaction is likely to reflect the person's fulfillment of his or her values and goals, and involves the search for meaningfulness in one's life. SWB becomes a broader measure of quality of life because it reflects deeper values beyond physical pleasure and ephemeral emotions.

Personality traits influence levels of subjective well being.
For example, Costa (1994) reviews evidence that even over a period as long as 30 years, adults are stable in their personalities. If biologically based personality predispositions influence SWB, we expect similar stability over time for SWB. In a longitudinal study, Magnus and Diener (1991) found that life satisfaction correlated .58 with the same measure administered four years later. Even when life satisfaction at time 1 was self reported and at the other time was reported by the family and friends of the respondent, the correlation over four years was .52. The use of two measurement sources is important in demonstrating that the stability of SWB is not simply an artifact or consistent response such as acquiescence or social desirability. The high correlations between self-report and informant report ratings of life-satisfaction, even over long time intervals, suggest that the basis for life satisfaction judgments is not only consistently used, but is substantive enough to be recognized by and communicated to friends and family members.

The affective components of SWB (pleasant and unpleasant affect) also exhibit stability across time. Watson and Walker (1996) found that trait affect scales showed a moderate level of temporal stability when assessed over a six year interval, and Costa and Mac Crae (1988) found that there were significant stability coefficients.
(in the 50 range) between spouses ratings of one’s emotion at time 1 and the target person’s self rating six years later.

Evaluations of one’s life, whether affective or cognitive, do not result from a purely “bottom up” process. People do not simply weigh the effects of various external circumstances to arrive at SWB judgments, because happiness remains moderately stable in spite of changing circumstances and changing environments. In fact, evaluations of specific events and domains in one’s life are colored by his/her overall happiness. Kozma (1996) reported that when respondents were asked to rate their satisfaction with various domains in their lives (e.g., work, home, relationships), these satisfaction judgements were correlated. If overall happiness was controlled, however, correlations among the different domains were no longer significant. These data suggest a top-down model in which a trait like construct of overall happiness influences feelings about specific domains. Thus, satisfaction with specific life domains likely is due to specific factors in that domain as well as substantial influence from the person’s general level of SWB.

Although traits such as self-esteem and optimism are not primarily affective in nature, there is reason to believe that they would influence or be influenced by well-being. Self esteem theorists, for example, hypothesize that positive evaluations of the
self are necessary for positive overall well-being. Lucas, Diener, and Suh (1996) showed that self-esteem and optimism do in fact correlate with measures of SWB such as life satisfaction, pleasant affect, and unpleasant affect.

Proponents of the temperament model (e.g., Eysenck, 1967, Gray, 1981, Larsen and Ketelaar, 1991; Headey and wearing, 1989) postulate a biological determinant of SWB. Headey and wearing, For example, suggest that a person's baseline level of happiness is decided by his or her temperament.

The general tendency toward positive thoughts would explain why the majority of people report positive levels of SWB (Diener and Diener, 1996). Perhaps more importantly for the current topic, individual differences exist in pollyannaism. Those who are able to recall more pleasant stimuli are also more likely to report that they are happy. It is possible that differences in accuracy and efficiency of processing pleasant information verses unpleasant information may lead to differential levels of well-being.

According to Lyubomirsky and Ross (1996), the happy person's world is one of attractive possibilities, whereas the unhappy person's world is "a place where one has been obliged to choose not between better and best, or even between good and better but rather between mediocre and bad or even between bad
and worse.” “(in press, p.28). The ability to focus on positive information may provide a cognitive strategy to increase well-being, and individual differences in this ability may influence well-being. People with high SWB are those who have developed effective strategies. For meeting their needs within the constraints of cultural expectations and life circumstances.

Personality is often the strongest predictor of SWB. Extraversion and neuroticism as well as narrower traits (e.g., self esteem and optimism) are consistently related to various cognitive and affective forms of SWB. These relations are particularly strong when the data are controlled for measurement error. The presence and characteristics of the goals that individuals work for in their lives are also related to well-being.

Subjective well-being reflects a stable and consistent phenomenon that is theoretically and empirically related to personality constructs.

There are three primary components of subjective well-being: satisfaction, pleasant affect, and low levels of unpleasant affect. Each of the three major facets of subjective well-being can be divided into sub-divisions. Global satisfaction can be divided into satisfaction with the various domains of life such as recreation, love, marriage, friendship, and these domains can be divided into facets. Pleasant affect can be divided into specific emotions such
as joy, affection, and pride. Finally, unpleasant or unpleasant affect can be separated into specific emotions and moods such as shame, guilt, sadness, anger and anxiety. Subjective-well being can be assessed at the most global level, or at progressively narrower levels, depending on one’s purposes. There is a tendency for people to experience similar levels of well-being across different aspects of their lives.

Cognitive theories of well-being and ill being within the behavioral sciences were developed in the last decades. For example, the attributional theory of depression is well-known. Depressed individuals are more likely to believe that negative events are caused by global and stable causes, such that negative are very likely to continue to happen to them. Beck (1967) popularized the idea that depressed people think about the world in self-defeating ways. In the area of subjective well-being, researchers find that one can dampen or amplify one’s emotions by what one thinks, and thereby experience more or less intense emotions (Larsen, Diener, & Cropanzano, 1987). Happy people are likely to experience more events that are considered desirable in the culture, but also have a propensity to interpret and recall ambiguous events as good. (Lyubomirsky & Ross, 1996, Seidlitz & Diener, 1993) People with high subjective well-being may not only experience objectively more positive events, but they also seen to
perceive events more positively than do people who are low in SWB.

Measures of subjective well being show moderate to high temporal reliability for example life satisfaction correlates .58 over a four year period, and this correlation remains strong (.52) when informant reports of life satisfaction are substituted at the second testing (Magnus, Diener, Fujita & Pavot, 1993). In addition pleasant affect and unpleasant affect have a degree of stability across a period of many years (e.g., Costa & MC Crae, 1988; Heady & wearing, 1992).

These findings suggest that SWB does change, but that there is some constancy in it even over a prolonged period.

Theories of coping are based on the idea that in order to cope with problems happy people initiate thoughts and behaviours that are adaptive and helpful, where as unhappy people cope in more destructive ways.

Temperament has a powerful effect an SWB studies of heritability in which twins separated at birth are studied as adults found that both pleasant and unpleasant affect have a strong genetic basis (Lykken & Tellegen, 1996; Tellegen, Lykken, Bouchard, Wilcox, Segal & Rich, 1988). Lykken and Tellegen estimated that 80 percent of the variability in long term negative affect is due to inherited characteristics. Although heritability
coefficients may differ in other environments, the twin data show convincingly that some proportion of SWB is due to one's genetic make up.

**Context theories**

Some theorists such as Veenhoven (1991) maintain that SWB is caused by the satisfaction of basic, universal human needs. Context theories emphasize that the factors that influence SWB are variable across both time and individuals, and that how good or bad life events are considered to be is based on the circumstances in which people live. The relevant context varies in different theories. In adaptation theory, for example, the relevant context is the person's past life, whereas in social comparison models the context is considered to be social others of whom the target individual is aware. Other contexts that could influence SWB are the person's ideals, and imagining counterfactual alternative situations.

**Telic theories**

This group of theorists explains that SWB is gained when goals and needs are reached (Diener 1984) Brunstein (1993) further found that a higher level of commitment, along with a sense of progress, contributed to higher SWB.

According to this theory, the extent that people have different goals, the causes of SWB ought to differ. For example,
the exact resources (e.g., money and social skills) the most strongly practiced SWB for an Individual are likely to be those that are required to gain his/her specific aims. (Diener & Fujita, 1995).

Mc Adams and vaillant (1982) observed that individuals high in intimacy motives exhibited higher overall psychological adjustment.

Health is positively related to well being. Self reports of health reflect one's level of emotional adjustment as well as one's objective physical health or condition (Hooker & Siegler, 1992; Watson & Pennebaker 1989), and the relation between health and emotional well-being is artificially inflated by this emotional component.

It has bee hypothesizeded that a persons level of subjective well-being is in part determined by comparisons he or she makes with standards (Michalos, 1985). Often peoples standards come from observing people around them or remembering what they themselves, were like in the past. It is hypothesized that if people exceed these standards, they will be happy and satisfied, but if they fall short of their standards, they will experience low levels of emotional well-being (e.g. Michalos, 1985).

People might increase their subjective well-being by the control of their thoughts. For example, subjective well-being can
be increased by believing in a larger meaning or Force in the universe. Support for this proposition comes from findings showing that on average religious people are happier than non-religious people (e.g. Ellison, 1991; Myers, 1992, Pollner, 1989). Further, SWB is higher if a person concentrates on attainable goals, and does not focus attention exclusively on distinct, difficult goals (Emmons, 1986, 1992). Finally, one can heighten subjective well-being by being optimistic about one's future. (Scheier & Carver, 1993)

Religiosity

Various fields of scientific psychology like more applied areas of clinical, counseling, health and rehabilitative Psychology, are becoming aware of and impressed by the religious concerns in people's life. Religion and spirituality are an integral part of human culture, and have the potential to shape individual lives and personalities.

Belief in God is a universal (although controversial) attitude that has existed almost as long as man and his myriad fears and anxieties. Belief in God is closely linked to the concept of religiosity. The word religiosity has emerged from the broad concept of religion, which may be said to be the recognition that all things are manifestations of a power which transcends our knowledge.
Philosophers and Psychologists, both agree that belief in God fulfills a psychological need which in the words of Galloway (1925) becomes more intense in situations of insecurity, fear, inadequacy and mental illness wherein the unsatisfied individual sees the faith in Almighty as satisfying a need in himself. The universality of a felt need is the secret of the universality of religion. For a psychologist like Erikson religion is an aspect of human life, which is to be accepted. According to him religion is the phenomenon which is translated into significant words, images, and codes both the exceeding darkness that surrounds man’s existence, and also the light which pervades, which apparently is beyond all comprehension. Erikson (1965) feels that certain factors like basic trust as well as the internalization of the creator-creation relationship are essential for human development and hence for religious development too. As a psychologist Erikson feels that young people need an ideology for their sense of identity in the form of unconscious tendency which underlies religious, scientific and potential thinking, binding together facts and ideas in such a way that a world image comes into being which supports the collective and the individual sense of identity i.e. the consciousness. One might be able to say “this is what I am and this is where I stand”.
For Sigmund Freud the value of religion for man consists solely in the importance which religious ideas have to him. He starts from the notion that the life on Earth is a burden. On Earth he is a helpless being and because of helplessness, he is in need of a father or God. Belief in God, therefore, springs from fear. Religion has to solve the riddle of the universe and to reconcile man to suffering and is marked by the tension between the pleasure principle and the reality principle with fear and sense of guilt as its concomitants. The positive aspect of the religion according to him is sublimation which in its comfortable form is one of the fortunate things of being able to come close to God.

According to Tillich (1951) religion can be seen as exploratory behaviour, driven among other things by man's curiosity and by his perpetual attempts to maximize contact with a maximal environment, to the full deployment of his potentialities. Broadly speaking, religious life may be divided into three phases: faith, thought and discovery. In the first phase religious life appears as a form of discipline, which the individual on the whole must accept as an unconditional command with any rational understanding of ultimate meaning and purpose of that command. Perfect submission to discipline is followed by a rational understanding of the discipline and the period religious life seeks its foundation in a kind of metaphysics, a logically consistent view of the world
with God as a part of that view. In the third phase metaphysics is disciplined by psychology and religious life develops the ambition to come into direct contact with the reality. It is here that religion becomes a matter of personal assimilation of life and power, and the individual achieves a free personality, not by releasing himself from the fathers of the law, but by the ultimate sources of the law within the depths of his own consciousness.

The climax of religious life, however, is the discovery of the ego as an individual deeper than has conceptually describable habitual selfhood. It is in contact with the most real that the ego discovers its uniqueness, its metaphysical status, and the possibility of improvement in that status. It seems that the methods of dealing with reality by means of concepts is not at all a serious way of dealing with it. Religion, which is essentially a mode of actual living, is not only serious way of handling reality. For those involved, religion is its another sphere of human quest and fulfillment, like relationships and work or like health or happiness, those not involved may see it in a more negative way. Watts and Williams (1988) have recently tried to provide a psychological model for religious knowledge. They suggest that it is like the insights and understanding achieved by a patient in psychotherapy. This is an intuitive, partly emotional process, rather than a rational one and is achieved by great effort. There is
a Complex relationship between mind, body and spirit. In a
analysis of 42 different clinical studies, MC Cullough (1998)
found that religious involvement was associated with lower death
rate, even after accounting for obvious health advantages such as
less alcohol and tobacco use and more social support.

According to a recent news week poll, 84% of Adult
Americans say they believe God performs miracles, and 48 percent
reported that they have experienced or witnessed one. In the
Quran, the prophet Mohammed is instructed to reject requests to
work miracles, as the Quran itself is the only miracle a Muslim
needs. Islam means submission to Allah; Sufi mystics who submit
their minds and bodies in total prayer achieve a level of spiritual
knowledge that produces Karamat (wonders). Miracles are found
in all five of the world’s major religions.

The notion that religious faith can promote Physical well
being is not new. Most of us have heard of cases in which
someone, seemingly by sheer faith and will, has miraculously
recovered from a terminal illness or survived for longer than
doctors thought possible. What is new is that such rewards of
religion are becoming the stuff of science. We can not prove
scientifically that God heals, but I believe we can prove that belief
in God has a beneficial effect”, declares Dr. Dale A. Matthews, a
medical professor. “There a little doubt that healthy religious
faith and practices can help people get better”.

More than 30 studies have found a connection between spiritual or religious commitment and longer life. Among the most compelling:

* A survey of 5286 Californians found that church members have lower death rates than non members regardless of risk factors such as smoking, drinking, obesity and inactivity.

* People with a strong religious commitment seem to be less prone to depression, suicide, alcoholism and other addictions, according to one research analysis.

Praying evokes beneficial changes in the body. When people pray, they experience some decrease in blood pressure, metabolism, heart and breathing rates as the famous “relaxation response” described by Dr. Herbert Benson of the Harvard Medical School. Patients also agree that prayer is a powerful tool in healing. Polls by TIME/CNN and USA weekend show that about 80 percent of Americans believe spiritual faith or prayer can help people recover from illness or injury.

“Religiousness is not a philosophy or a theology. It is like love.... The highest, most refined quality of love. You love one person-Religiousness is falling in love with the whole existence.” (says Ocho, The Zen Master)

Religious faith leads into a unquestionable belief in a
transcendental reality which is regarded as the ultimate. The incomparable spiritual power of Prophets posthumously influencing billions of people centuries and throughout the development of civilization has its roots in faith. Faith, is therefore, a tremendous power in itself. ‘Almost all religions based on faith support man’s aspiration for the continuation of his identity and existence after death.’ Rabbi Rachel Cowan, Director of The Jewish Life Program, explained a physiologically adaptive basis for religion, she says, “(religious) rituals gives you a bearing in time and space. It connects you with a source of hope. She further stated “healing does not mean curing. You live in deep emotional and beautiful spiritual discovery, and it makes you feel authentically loved.” It changes the experience of illness.

In a study of 91,909 individuals in Maryland, those who attend church once or per week had:

- 50% fewer deaths from coronary artery disease
- 56% fewer deaths from emphysema
- 74% fewer deaths from cirrhosis
- 53% fewer suicides

Religion seemed to help in recovery. Patients with higher intrinsic (inner) religiosity scores had more rapid remissions than patients with lower scores. The researches found that religious faith may provide patients with a sense of hope that things will
turn out all right regardless of their problems and thus, foster
greater motivation to achieve emotional recovery.

Psychiatrist Dariel Larson, who specializes in studying the
effects of religion on physical health and mental health found that
people, who have faith consistently exhibited higher levels of
mental, physical and relational wellness. Larson found that “In the
area of Psychiatry, 92% of the finding showed that religious
commitment produced some kind of beneficial effect”. Larson and
his colleagues found that in almost every instance, religious people
lived longer than non religious people even when into account
“other risk factors such as weight, age and smoking.”

In 1987 researchers of University of Texas “Carefully
examined 27 studies on church attendance and health”. Their
analysis revealed that in all but seven studies. “ Frequent Church
attenders were healthier as a group than less frequent attenders.”
David Larson, in a study of men’s blood pressure, found that
“even smokers benefited from religion”. Larson found that
smokers who were not religious “were seven time more likely to
have abnormal blood pressure than those who said religion was
important”.

Recent studies revealed that “religious people seems to be
better of psychologically than non religious people.” According to
a study conducted at the University of Akron in Ohio, “people who
spent more time absorbed in prayer have a greater sense of well-being than people who did not pray or prayed very little. "Other studies suggest that religion helps people ward off the more serious Psychological effects of stress." A recent study reveal that regular church attenders had fewer psychological disorder over time than non-attenders despite reporting same level of life stress."

At present there is presence of spiritual and religious belief in Medical practice. JAMA created a medicine and religion department and has since periodically published review article on medicine and religion most of the research suggest that an active religious commitment is "beneficial for preventing mental and physical illness, improving recovery and enhancing the ability to cope with illness. Religion may promote help by adding social or psychological support (or both) to people's lives. Religion can also improves the quality of life by enhancing patients subjective well-being, social support and stress and coping strategies, by providing systems of meaning and existential coherence by establishing personal relationship with one's deity, and by ensuring social support and integration with in community.

In the "Two versions of Man" (1960), which was presented at one of the first star island conferences on science and religion, Murray argued for a new definition of religion, compatible with
science, that would be a center of gravity that attracts, binds and unifies the peoples of the free worlds. "Personality psychologist are said to provide glimpses of what its like to be human" (Carver, 1996). Religious goals, belief and practices are not only a distinctive component of a person, for many they are the core of personality. Many researchers have demonstrated the beneficial impact of religious faith and practices on psychological, physical and interpersonal functioning (Benson, 1996 Koenig, 1998; Matthews & Clark, 1998; Paloutzian & Kirpatrick, 1995, Pargament, 1997, Richards & Bergin, 1997; Shafranske, 1996). The “faith factor” emerges as a significant correlate of mental health indices of life satisfaction, happiness, self-esteem, hope and optimism, and meaning in life.

According to data recently published by the Princeton Religious Research Centre, the percentage of American who belief that the influence of the religion is increasing its influence (For better or worse) in society is now the highest it has been in 12 years. ("Dramatic Rise seen", 1998)

Some research suggest that religious involvement is favourable associated with measures of physical health such as high blood pressure (Levin & Venderpool, 1989), Cancer (Jarvis & North cott; 1987), heart diseases (Fried Lander, Kark, and Stein, 1986), Stroke (colantonio, Kasal & Ostfield, 1992), and suicide
(Kark, Shemi et al., 1996). Other studies suggest that religious involvement helps to buffer the impact of stress on physical and mental health (Kendler, Gardner, & Prescott, 1997, Krause & VanTran, 1987, Pressman, Lyons, Larson, & Strain, 1990). Some data suggest that the association of religious involvement with mortality might be stronger in women than in men (House, Robbins, & Metzner, 1982, Strawbridge et al., 1997).

EGO STRENGTH

Freud (1924) used the construct of ego but did not expound upon it rigorously until the publication of Das Ich and Das ES in 1923 (Freud, 1927). Freud tells us that “the ego has the task of bringing the influence of the external world to bear upon the id and its tendencies, and endeavours to substitute the reality principle. The reality principle for the pleasure principle which reigns supreme in the Id... the testing of reality is rather one of the functions of the ego.” (Freud, 1927, p.30). According to Hinsie and Campbell (1963), the ego is “A part of the physic apparatus which is the mediator between the person and the reality, the perception of reality and adaptation to it.”

Symonds (1949), a leading psychoanalyst, maintains that the term ego is “used to refer to that phase of personality which determines adjustment to the outside world in the interest of satisfying inner needs.” This concept of ego has, however, been
modified by some recent ego-psychologists, who view ego as having a source of energy of its own, and as taking pleasure not only in the gratification of id impulses, but also in the mastery of the environment (Pervin, 1970, p.228).

Cattle (1949) has considered ego-strength as one of the factors of personality which is commonly known as “Ego-weakness vs. Higher ego strength” and it refers to the ability of a person to maintain ego and adjustment. Barron (1953) conceptualization of ego-strength, derived from the ego-strength scale item content and personality and intelligence test correlate involves physiological stability and health of personal adequacy and vitality, permissive morality, lack of ethnic prejudice, emotional outgoingness and spontaneity and intelligence.

To Pederson (1965) ego strength is a person’s ability to deal with reality. He observed that subjects with high ego-strength will have greater unconscious concern for achievement than subjects with low ego-strength.

Ego-strength can be defined as the total psychic energy at the disposal of the individual enabling him to enjoy his strivings to master the environment. It is not the amount of troubles, conflicts, and crisis that a person encounters but the manner and confidence with which he encounters them. Ego-strength is an important factor determining the capacity of an individual to
perceive a challenging situation realistically, to decide the course of action rationally, and to execute the response effectively. Barron, in creativity and personal freedom (1968), while dealing with ego-strength, maintains that the most important consideration in judging the strength of a person’s ego is not the amount of troubles, conflicts, and crisis he encounters but the manner and confidence with which he encounters them. The capacity to meet the problems and challenges of life without being dismayed, and to endure suffering without foundering are the marks of ego-strength. An important aspect of ego-strength according to McClelland (1951), is the accuracy of the individuals self-picture. An accurate self-picture should include all the significant self-related perceptions even if they are consistent and unfavourable.

SOCIAL SUPPORT:

Man is a social animal and the ordinary healthy human being finds prolonged isolation a severe punishment. We have all heard a song "No man person is an Island". The importance of closeness with spouse, with friends or with family members is taken for the prediction of healthy functioning (Berkman & syme, 1979) Jacobs & charles, 1980; Medalie & Gold bourt 1976; Thomas & Duszynki 1974). Literature on social support also suggests that it is an important concern in our daily lives social interaction with family and friends is an integral element of mental and physical health.
Lack of social support has been associated with risks for emotional problems, excessive worry, self preoccupation and stress proneness (Blazer, 1982, House et al., 1982) The concept of social support has variously been defined by the researchers as social bonds (Henderson, 1977), social networks (Mueller, 1987) meaningful social contact (Cassel, 1976), availability of social confidents (Brown et al., 1975) and human companionship (Lynch 1977); Cohen & syme (1985), and House & Kahn (1985) called social networks as structural support, structural support refers to the existence of an inner-connection between social ties (e.g. marital status, close family and friends) participation in group activities and religious group activities. It is an important predictor of healthy psychological and physiological functioning.

Social support which means turning to other people for support in times of personal crises, is one of the most often used coping strategies. Social support refers to the perceived comfort caring, esteem or help a person receives from other people or groups. Cabb, 1976, Gentry & Kobasa, 1984, Wallston et al., 1983; Wills, 1984. According to Cobb (1976) people with social support believe they are loved and cared for, esteemed and valued and part of a social network, such as family community organization, that can provide goods, services and mutual defenses at times of need or danger.
Health Psychologists have extensively studied the association between social support and mental and physical health and found it is extremely beneficial in highly stressful situations. There are different forms of social support. One type is practical support, which includes rides to the doctors office or help around the house. The next type is emotional support which refers to reassurance, trust and dependence. The final form of social support is appraisal support, such as help in figuring out what is happening and how to cope with it.

Health psychologists have found that family relationship play an important role for the patient's adaptation to the serious illness. The family seems to be the vital source in the overall adjustment.

If support is nonexistent for the patient, then they may respond negatively to their illness and keep their illness or problems hidden, which causes more stress for themselves.

Kahn (1979); Kahn and Autonucci, (1980) define social support - as the expression of liking, admiration, respect, love agreement and affirmation as well as the provision of direct aid and assistance. It is apparent that social support is multidimensional construct, which not only represents that the person has social relationship but also indicates that he is esteemed and cared for. As a product of social activities or transactions he perceives that a
support can come from many different sources, the person’s spouse or lover, family, friends or community organizations, etc.

Another aspect of social support is the kind of help person receives from other i.e. emotional, personal, practical, informational, and instrumental. According to Caplan’s theory (1974), social support implies enduring pattern of continuous or intermittent ties that play a significant role in maintaining the psychological and physical integrity of the individual over time. For Caplan a social network provides a person with “Psychosocial supplies for the maintenance of mutual and emotional health”. According to Shumaker and Brownell (1984) supportive behaviour would be seem as an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of recipient. These interactions tend to be viewed as supportive when they are intended to gratify people’s need (Thoits, 1983).

Social support: Health and well-being.

Researches have proposed two theories the “buffering” and the direct “effects” hypothesis to explain the influence of social support on health and well-being. Studies have found evidence consisted with both theories (Cohen & Wills, 1985; Thoits, 1982; Wortman & Dunkel-Schetter, 1987)
**Buffering Hypothesis**

According to this hypothesis, social support affects health by protecting the person against those negatives effects of high stress. This hypothesis states that protective function is effective only when the person encounters a strong stressor under low stress conditions, little or no buffering occurs. Cohen and Wills (1985) suggested that there are at least two ways of the buffering process. One way involves the process of cognitive appraisal. When people encounter a strong stressor, such as a major financial crisis, those individuals with high levels of social support may be less likely to appraise the situation as stressful than those with low levels of support. Individuals with high social support may expect that someone they know can and will help, such as by providing the needed money or going advice on how to get it. As a result they judge that they can meet the demands and decide that the situation is not very stressful. Social support can buffer the effects of stress by modifying people’s response to a stressor after they have appraised the situation as stressful. For example, people with high social support might have someone to provide a solution to the problem, convince them that the problem is not very important, or cheer them on to ‘look on the bright side or count their blessing’. People with little social support are much less likely to have any
of these advantages so the negative impact of the stress is greater for them then those with high levels of support.

**Direct Effects Hypothesis**

This hypothesis maintains that social support is beneficial to health and well-being regardless of the amount of stress people experience. According to this hypothesis, the beneficial effects of social support are similar under high and low stressor intensities. There are several ways by which direct effects may work (Cohen & Wills, 1985; Worthman & Dunkel Schetter, 1987). For instance, people with high levels of social support may have a greater sense of belongingness and self-esteem than those with little support. The positive effects of this hypothesis could be beneficial to health independently of stress experiences, such as making individuals more resistant to infection. High levels of support may also encourage people to lead more healthful lifestyles than low social support does people with social support may feel for example, that because others care about them and need them, they should exercise, eat well and seek medical attention before a problem becomes serious.

Observation in a variety of settings have led to the idea that social support:-

a) Contributes to positive adjustment and personal development and increased well-being in general (Branda et al, 1980; Cohen &
Wills, 1985) and (b) provides a buffer against the psychological consequences of exposure to stressful life events. (Cohen & Syme, 1985; Cohen & Wills, 1985; Kessler & Mcleod, 1985).

Unden (1994) studied social support at work and its impact on health. Social support had a predominantly linear relationship with heart rate; subject with the least social support had the highest heart rate.

Researchers in the area of social support have found common themes related to the perception of outcomes of interaction between people. In this view there are five outcomes constituting social support (i) the perception of a positive emotion towards oneself from another, (ii) having one person agree with one's beliefs or feelings, (iii) encouragement by another person to express one's beliefs or feelings in a non-threatening environment, (iv) the receipt if needed good or services and (v) confirmation that others will be there to when needed. The perception of social support services, an important function, is maintaining a positive sense of well-being by enabling one to cope with and adapt to stress. It has been shown to have a positive effect on physical as well as on mental health.

Social support can influence our health by making us less likely to experience negative emotions (Cohen & Herbert, 1996; Cohen 1988). Given the well established link between Chronic
negative emotions and poor health, a strong social support network can promote positive mood and emotions, enhance self-esteem and increases feelings of personal control. (Rodin & Salovey, 1989).

Relationships are the basis of social support one of the main sources of happiness and of mental and physical health. Berkman and Syme (1979) found that the presence of intimate ties with friends and relatives were strongly related to low mortality rates and people who lacked community ties had considerably higher death rates than people with extensive social contacts. However, they also found that deficits in family’s friendship ties were more strongly related to mortality than were deficits in more general community ties. Implicit in such findings was the idea that intimate type of relationship (such as with friends & family) were the greatest sources of support.

Older people who lack social support may be at increased risk of heart disease, new researches shows. People low in social support, diastolic blood pressure averaged about 63 for young people, 74 for older people. In individuals with strong social support, the average for young participants was 67, for older ones 68.

Number of studies showed that low levels of social support and of participation in social network are related to increase risk of CHD. This has led to two hypotheses: either social isolation is
in itself a stress that increases the risk of disease, or social support acts as a buffer that helps people to cope with other stressful circumstances (Pestonjee, 1999), (Mohan 2000).

Need of the present study:

1) Psychosocial assessment of hypertension and bronchial asthma patients is well studied in the fields of clinical and health psychology. By and large results indicates that cardiovascular disorder patients (i.e. hypertensive) and respiratory disorder patients (i.e bronchial asthma) are exposed to various psychosocial problems. It is therefore needed to allievate these problems of the patients so that they are able to attain a healthy lifestyle.

The present study is an attempt to know the various psychosocial aspects of bronchial asthma and hypertensive patients and the effect of these aspects on their well-being.

Little research has been done to assess the impact of various Psychosocial factor like religiosity, ego-strength and social support on subjective well-being of bronchial asthma and hypertensive patients. The role of these variables in respiratory disorders has not been studied extensively. Also the effect of the ego-strength on subjective well-being of respiratory and cardiovascular disorder patients has not been studied.

It is accepted that the findings of this investigation would have much relevance for improving the health status and quality of life of bronchial asthma and hypertensive patients.
Research Objectives

The main objectives of the present study are as follows:

1. To determine the relationship between subjective well-being and religiosity, subjective well-being and social support and subjective well-being and ego-strength, religiosity and ego-strength, religiosity and social support, ego-strength and social support among male and female patients of bronchial asthma.

2. To determine the relationship between subjective well-being and religiosity, subjective well-being and social support and subjective well-being and ego-strength, religiosity and ego-strength, religiosity and social support, ego-strength and social support among male and female patients of hypertension.

3. To determine the relationship between subjective well-being and religiosity, subjective well-being and social support and subjective well-being and ego-strength, religiosity and ego-strength religiosity and social support, ego-strength and social support among male and female patients of bronchial asthma and hypertension.

4. To determine the partial correlations between subjective well-being and religiosity scores (when the variables of ego-strength and social support are partialled out), between subjective well-being and ego-strength scores (When variables of religiosity and social support are partialled out), between
subjective well-being and social support (when the variables of religiosity and ego-strength are partialled out), between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out), between religiosity and social support (when the variables of subjective well-being and ego-strength are partialled out) and between ego-strength and social support (when the variables of subjective well-being and religiosity are partialled out), among male and female patients of bronchial asthma.

5. To determine the partial correlations between subjective well-being and religiosity scores (when the variables of ego-strength and social support are partialled out), between subjective well-being and ego-strength scores (when variables of religiosity and social support are partialled out), between subjective well-being and social support (when the variables of religiosity and ego-strength are partialled out), between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out, between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out, between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out, between religiosity and ego-strength (when the variables of subjective well-being and religiosity are partialled out), among male and female patients of hypertension.
6. To determine the partial correlations between subjective well-being and religiosity scores (when the variables of ego-strength and social support are a partialled out), between subjective well-being and ego-strength (when the variables of religiosity and social support are partialled out), between subjective well-being and social support (when the variables of religiosity and ego-strength are partialled out), between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out), between religiosity and social support (when the variables of subjective well-being and ego-strength are partialled out) and between ego-strength and social support (when the variables of subjective well-being and religiosity are partialled out), among male and females patients of bronchial asthma and hypertension.

7. To determine the significance of partial r (r12.34, r13.24, r14.23, r23.14, r24.13, r34.12) at the 0.95 confidence interval among male and female patients of bronchial asthma.

8. To determine the significance of partial r(r12.34, r13.24, r14.23, r23.14, r24.13, r34.12) at the 0.95 confidence interval among male and female patients of hypertension.

9. To determine the significance of partial r (r12.34, r13.24, r14.23, r23.14, r24.13, r34.12) at the 0.95 confidence interval
among male and female patients of bronchial asthma and hypertension.

10. To determine the multiple coefficients of correlations between scores actually earned and scores predicted on the subjective well-being from the three variables – religiosity, ego-strength and social support among male and female patients of bronchial asthma.

11. To determine the multiple coefficients of correlations between scores actually earned and scores predicted on the subjective well-being from the three variables – religiosity, ego-strength and social support among male and female patients of hypertension.

12. To determine the multiple coefficients of correlations between scores actually earned and scores predicted on the subjective well being from the three variables, religiosity, ego-strength and social support among male and female patients of bronchial asthma and hypertension.