CHAPTER - II

Review of Literature
The review of Literature includes only those studies which have relevance and relation with the variables of the present study. The main thrust of the present study is on the impact of religiosity, ego-strength and social support on subjective well-being of the bronchial asthma and hypertensive Patients. Although reviews of the relation between subjective well-being and social support have been published, no researches to date have examined the association of subjective well-being and ego strength, religiosity and ego strength. Studies are grouped into the following main heads:

**SUBJECTIVE WELL-BEING:**

McIlvane and Reinhardt (2001) examined the interactive relationship of high and low friend and family support for adaptation to chronic vision impairment among in 241 men and women (aged 65-99 yrs old). Two 2 (High/low family support) x 2 (High/low friend support x 2 (Gender) multivariate analysis of covariance tested for Psychological well-being, one with qualitative support measures, the other with quantitative support measures. Two analyses of covariance models tested for adaptation to vision loss. A significant multivariate 3-way interaction effect for quantitative support was found. Women with high support from both friends and family had better psychological well-being. Whereas men with high support from both friends and family or
just from family had better psychological well-being. Two univariate main effects showed that participants with high qualitative friend support and high quantitative family support had better adaptation to vision loss. Findings demonstrate the complexity of measuring and understanding relationship among social support, well-being, and domain-specific adaptation to chronic impairment.

Peck (2001) examined that lower levels of subjective well-being are associated with increased illness and death. Studies of elder morbidity and mortality increasingly have explored the link between social and psychological aspects of life to subjective well being, and to health and disease. This paper presents a conceptual model of subjective well-being based on the process that people use to appraise their lives and on life task completion. Theories of social cognition inform the life appraisal process and provide a framework for interventions. Life review therapy is detained as a social work intervention to enhance the subjective well-being of older adults.

Daaleman, Cobb and Frey (2001) identified and described elements of patient reported, health related spirituality. A qualitative study utilized focus group interviews of 17 women with type 2 diabetes mellitus; there were 18 controls. Participants narratives were coded into 8 conceptual categories; (1) change in
functional status, (2) core beliefs, (3) medical/disease state information gathering and processing, (4) interpretation and understanding (5) life scheme, (6) positive intentionality, (7) agency, and (8) subjective well-being. A change in functional status was the catalyst for 2 process-oriented categories, Medical disease state information gathering and processing, and the higher order interpretation of understanding of life events. Participants tied the attitudes and practices of positive intentionality with agency, or the use of exertion of power through belief, practice or community. They outlined positive affective and cognitive components of subjective well-being. Patients described several interrelated elements and a process of events in their depiction of spirituality in healthcare settings. Patients reported spirituality is predominantly a cognitive construct incorporating the domains of life scheme and positive intentionality.

Steverink, Wasternof et al (2001) examined the personal experience of aging, the resources relevant to it, and the consequences for subjective well-being in a sample of 4,034 German adults aged 40-85 yrs old. The data revealed 3 dimensions of aging experiences as particularly relevant: (a) physical decline (b) continuous growth, and (c) social loss. Not only being younger but also having better subjective health, higher income, loss loneliness, higher education, and greater hope were negatively
associated with physical decline and social loss are positively related to continuous growth. The number of children participants had played no role. All three dimensions of the aging experience were also found to be related to both positive and negative affect and, with the exception of physical decline, to life satisfaction.

Hilleras, Aguero, Hedda and Winblad (2001) examined the factors that either increase or decrease well-being in both young and old people. Many factors have been studied in relation to well-being but only some have been found to be associated with it. These factors are demographic (age, sex, culture, marital status), social (Socio economic status, having children, religion, social contacts) or are related to personality, life events, health, and activities. However some of these factors have a stronger association than others.

Harrington and Loffredo (2001) examined the relationship between psychological well-being, life satisfaction, self-consciousness, and the four Myers-Briggs Type indicator dimensions. The participants were 97 college students. All the subjects were administered four instruments, the Psychological well-being inventory (C.D. Ryff, 1989), the satisfaction with life scale (E. Diener et al, 1985), and the self-consciousness scale. Revised (M.F. Scheier and C.S. Carver, 1955), and the MBTI (from G self-scoring), MANOV as revealed significant differences
on three of the four dimensions of the MBTI with extraverts showing higher psychological well-being and life satisfaction and lower self-consciousness than introverts. Correctional analyses showed that most dimension of psychological well-being were negatively related to self-consciousness. The relationship between life satisfaction and personality variables are discussed.

Wallace, Bisconti and Bergeman (2001) Examined resilience resources as they relate to health and well being in an elderly sample. It is suggested that these resources serve as reserves than an individual can use to compensate for age related loss. Of particular interest in this study are the internal personality reserve hardiness, and the external reserve, social support in Ss, aged 60-95 years. Hardiness was examined as both a mediator and moderator of the relation between social support ie, quantity of family support and friend support) and outcome (depression life satisfaction, and self-reported health). Across type of support and outcome, evidence was found for the mediational model, suggesting that the relation between social support and outcomes decreases once hardiness is taken into account. Model-fitting analyses provided additional support for the mediator model once error had been attenuated overall, these results suggest that consideration of either construct alone may be loss complete than consideration of them in combination.
Eiser, Riazi, Eiser, Hammers and et al (2001) examined psychological well-being and individuals representations of their illness among 96 patients with type 1 diabetes and 139 patients with type 2 diabetes. Metabolic control and the presence of diabetetic complications (e.g., retinopathy, neuropathy) were also recorded. Type 2 patients tended to be older and be experiencing more complications than type 1 patients. Women reported lower well-being than men. Type 1 and Type 2 patients did not differ in terms of well-being, but the predictors of well-being were somewhat different in two groups. In both groups, well-being was related to control beliefs, (Confidence in self management and ability to delay complications) and to lower ratings of the extent to which diabetes interfered with everyday activities. For type 1 patients only, well-being also related to a tendency to perceive their diabetes as having minimal impact on their lives. Metabolic control showed no consistent relationship with Psychological variables, but the number of complications significantly predicted lower well-being among Type 2 patients only. It is argued that well-being is a function both of illness representations and the actual experience of complications, which are more prevalent among those with type 2 than type 1 diabetes.

Diener, Lucas, Oishi, Shigehiro and suh (2002) in 2 large international studies of subjective well-beings, the authors
examined that whether happy and unhappy individuals weighted life domains (health, finances, family, friends, recreation, religion, self and education) differently when constructing life-satisfaction Judgements. In both studies, regression equations predicting life satisfaction showed that there were significant interactions between happiness and a person's best and between happiness and a person's worst domain, even after controlling for participant's standing on all other domains. Happy participants weighted their best domains more heavily than did unhappy individuals, whereas unhappy individuals weighted their worst domains more heavily than did happy individuals. Thus happy and unhappy people used different information when constructing satisfaction judgements.

Vitters, Nilsen and Fredrik (2002) examined two things (1) to analyze and explore the conceptual structure of subjective well-being SWB, neuroticism (n) and extraversion (E), and (2) to compare the effect size of N and E as predictors of SWB. The sample comprised 461 participants representative of adult population in Northern Norway. Analyses were conducted by means of structural equation modeling (SEM), and the results on (1) supported the notion of an overall subjective well-being construct sustained by the three nested dimensions of life satisfaction, positive affect, and negative affect. A simple factor structure for N and E was not supported, and considerable
modification was needed to provide even a Mediocre goodness of
fit for the trait model. On (2), N explained eight times as much of
the SWB variance as did E. Moreover, through comparison of
several models it was revealed that if E is the sole predictor of
SWB, the influence of E on SWB is overestimated by a factor of
seven. Since N and E are strongly and negatively correlated, the
model comparison demonstrates the importance of including both
E and N as independent variables in regression models of SWB.

RELIGIOSITY:

Saunders, and Kong (1983) examined the role of Churches in
hypertension management. Describes three year experience in the
establishment and functioning of Church-based hypertension
programs in ten medium to major size U.S. cities, also describes
hypertension screening and education programs.

Trappier and Endicott (1997) Comments on the article by
properties of religiosity. The authors note their study (B. Trappler
et al 1995) of a homogeneous group of returnees to the Lubaritch
scet of orthodox Judaism. it was concluded the SS ability to
internalize religion and make effective use of a close community
support system to butter them against stressful life events appear
cal to have been influence by genetic or environmental factors
before their religious conversion
Hettler and Cohen (1998) examined the stress buffering effect of an intrinsic religious orientation for a community sample of adult Protestant Churchgoers. At time 1, participants completed measures of intrinsic religiousness, religious activity and dysphoria. At time 2 eight months later, they completed measures of negative life and dysphoria. For participants from liberal protestant Churches. (e.g. Methodist), intrinsic religiousness served as a stress-buffer in the predication of time 1-time2 residual change in dysphoria. Single item measures of religious importance, frequency of prayer, and frequency of Church attendance served as stress-buffers for liberal participants, but not for conservative participants. The non-significant effects for the later participants are attributable to their restricted range on the religion variables. The result for the former participants suggests that religious “Commitment” is an individual difference variable that influences adjustment to negative life events.

Meisenhelder and Chandler (2000) questioned 71 native Americans (aged 65-92 yrs.) living in the general community on their frequency of prayer, importance of faith, and their health status. The researchers hypothesized that people with higher scores in faith and prayer would experience a more positive health status. Self-reports of health indicated a high level of functioning overall. Older people and those living alone had poorer physical
and emotional health outcomes than younger elders and those living with one or more persons, although neither age nor living situation was related to mental health people who prayed more often and those who indicated a high importance of their faith scored higher in the mental health sub scale, confirming the hypothesis for this dimension of health.

RELIGIOSITY AND PSYCHOLOGICAL WELL-BEING:

Witter, stock, Okum, and Haring (1985) examined religion and subjective well-being in adulthood: 56 religion/subjective well-being effect sizes examined., quality of study ratings made using a survey evaluation instrument used by Kohr & Suydam (1970)., the mean sample size weighted correlation was 0.16 (9570 CI 0.14-0.25)., study quality ratings were unrelated to effect size., religion was more strongly related to well-being in earlier studies., relationship was stronger in older than younger subjects, but not by sex., mean effect sizes were greater for religious activity (weighted m=18) than for religiosity (.13)., religion is as strongly, or more strongly related to subjective well-being. 2-6% of variance in SWB of adults is account for by religious belief which was larger than marital status, economic well-being, and other variables.

Courtenay, Poon, Matin, Clayton and Johnson (1992) measured religiosity by 23-item questionnaire of Faulkner and
DeJong (1966) belief, knowledge, ritual, attendance, prayer, Bible), experience, and consequential), ritual dimension was uniformly positive related to health conditions: cardiovascular (.22, P<.01), neurological (.24, P<.01), musculoskeletal (.24, P<.05), respiratory (.23, P<.01), and overall (.23, P<.01). Overall religiosity score was positively related to neurological and musculoskeletal disorders. Results suggests that religious persons likely to use religious coping as a method of dealing with health problems, for overall religiosity and each of the 5 dimensions, centenarians (n=31-35) had the highest mean score, followed by octogenarians (n=33-37) and the sexagenarians (n=44-47), suggest that for religious belief, knowledge, and reliance on religion in daily life, there is a linear increase with age.

RELIGIOSITY AND WELL BEING:

Atchley (1997) examined whether the subjective importance attached to being a religious person influenced health or psychological well-being 14 years later. Data were drawn from the Ohio longitudinal study, a study of aging and adaptation in a panel of more than 1,100 adults who were aged 50 or over when the study began in 1975. About two third of the panel reported consistently positive attitudes towards being religious throughout the study, about 16% were consistently negative in terms of the importance being religious had no predictive value in
understanding variation in health or psychological well-being in 1991. Religious affiliation and frequency of attending religious function were also unrelated to health or psychological well-being. These result call into question conclusions of earlier reviews (e.g., Koenig, 1994-95) of the literature.

Koenig (1998) examined the prevalence of religious beliefs and practices among 455 medically ill hospitalized older adults (mean age 70.2 yrs) and related them to social, psychological and health characteristics. Ss admitted to the general Medicine, Cardiology and neurology services of a University medical center completed measures of religious affiliation, religious attendance, private religious, intrinsic religiosity and religious coping. Demographic, social, psychological and physical health characteristics were also assessed. 53.4% of Ss reported attending religious services once per week or more often; 58% prayed or studied the Bible daily or more often. Over 85% of Ss held intrinsic religious attitude, and over 40% spontaneously reported that their religious faith was the most important factor that to cope. Religious variables were consistently and independently related to race, lower education, higher social support and greater life stressors. Religious attendance was associated with less medical illness burden and lower depressive symptoms.
Maltby, Lewis and Day (1999) examined the role of religious acts between measures of religious orientation and Psychological well-being, and also examined the theoretical view that religion can act as a coping mechanism. Correlational statistics, principle components analysis with Oblimin rotation, and multiple regression were used. Ss aged (18-29 years) were administered questionnaire measures of three aspects of religious orientation (intrinsic, extrinsic; Quest), frequency of personal prayer, and Church attendance, alongside measures of depressive symptoms, trait anxiety, and self-esteem. A number of significant correlations were found between measures of religiosity and psychological well-being. A multiple regression analysis using identifiable religious components suggests that frequency of personal prayer is the dominant factor in the relationship between religiosity and Psychological well-being. The results suggest two points: (1) the correlation between a number of measures of religiosity and Psychological well-being may be mediated by the relationship between frequency of personal prayer and psychological well-being. (2) Personal prayer may be an important variable to consider within the theory of religious coping.

RELIGIOSITY AND BLOOD PRESSURE:

Hixon, Grachow, Harvey and Morgan (1998) examined the association between BP, selected health behaviours, and various
dimensions of religiosity among 112 females (aged 35-85 yrs) of Judeo-Christian faiths. Resting BP measures were taken with an automated sphygmomanometer, height and weight were measured to determine body mass index, and intermediate health variables (e.g. physical activity, smoking, diet, and Alcohol consumption) were measured by questionnaire. A multifactorial questionnaire was used to assess various dimensions of religiosity. Multiple regression path-analyses were conducted to determine the direct and indirect effects of religiosity on BP with age and body mass index controlled atavistically. The results supports a direct relationship between religiosity. Results also indicate that religious experiences may exert a greater beneficial effect on diastolic BP in older (50-80 yrs) age group.)

Hixson, Gruchow and Morgan (1998) examined the relation between religiosity, selected health behaviors, and blood pressure among adult females. Cross-sectional data were obtained on 112 white female of at least 35 years of age and of Judco-Christian faith. Resting blood pressure, height and weight were measured to determine body mass index (BMI). Physical activity, smoking, diet, and alcohol consumption was measured by questionnaire. A multifactorial questionnaire was used to measure religiosity. Multiple regression path analyses were conducted to determine the direct and indirect effects of religiosity on blood pressure. Age
and BMI were controlled statistically. The direct effects of religiosity on systolic blood pressure (SBP) and diastolic blood pressure (DBP) were more substantial than the indirect effect through the intermediate health variables, though not significant. In general, DBP was more influenced by religiosity than SBP, and the dimensions of intrinsic religiosity and religious coping were most influential.

Koenig, George Cohen, Hays, Blazer, Larson (1998) examined the relationship between religious activities and blood pressure in community-dwelling older adults. Blood pressure and religious activities were assessed in a probability sample of 3,963 persons age sixty-five years or older participating in the Duke EPESE Survey. Participants were asked if their doctor had ever informed them that they had high blood pressure and if they were currently taking medication for high blood pressure. Systolic and diastolic blood pressures were measured following a standard protocol. Data were available for three waves of the survey (1986, 1989-90 and 1993-94). Analyses were stratified by age (65-74 vs. over 75) and by race (Whites vs Blacks) and were controlled for age, race, gender, education, physical functioning, body mass index, and, in longitudinal analyses, blood pressure from the previous wave. Cross-sectional analyses revealed consistent differences in measured systolic and diastolic blood pressure
between frequent (once/wk.) and infrequent (.0001). Participants
told they had high blood pressure; religiosity active persons were
more likely to be taking their blood pressure medication.

RELIGIOSITY AND HYPERTENSION MANAGEMENT:

Brown (2000) examined the role of religiosity in
hypertension management among African Americans. Data were
collected from in depth; personal interviews with 20 African
Americans aged (23-78 yrs) who had been diagnosed with
hypertension for at least 1 year. A majority of the participant used
their religious believe as protective, control and coping
mechanism in the management of hypertension. Their personal
religious commitment enables them to feel protected from
immediately and long term negative consequences of hypertension,
as well as find meaning in and exert control over hypertension
management. Further, more religious believe served to enhance
their ability to cope with having hypertension. These findings
support the utility and value of religiosity in the management of
hypertension among African American.

SOCIAL SUPPORT:

Walsh and Walsh (1987) examined social support, assimilation
and biological affect on blood pressure levels. Sample consisted of
137 immigrants in Toledo, Ohio (50 percent men and 50 percent
women) snow-balling technique was used to acquire the sample.
blood pressure readings were taken using standard procedure with patients seated. A "biologic effective blood pressure" was calculated using a standard formula, which basically involved averaging the systolic and diastolic blood pressures. Frequency of Church attendance was assessed as never or only on special occasions, once or twice a month, once a week, and more than once a week (1-4). Frequency of religious attendance was significantly associated with assimilation (measured with a 12-item major assessing respondents acceptance of and closeness to America and Americans), (0.36, P<.0001) and was inversely related to blood pressure (-.17, P<.05). After controlling for age, sex, positive affect, general cardiac health, assimilation, occupation, education, income, and marital status using multiple regression, Church attendance continued to inversely predict blood pressure (-.16, P<.05).

Cheung, sun, Mak and Fung (1997) investigated the differential effects of social support on the psychological well-being of sociotrophic and autonomous individuals using 2 wave prospective design, 75 college students responded to the Chinese sociotropy-Autonomy scales (SAS). Index of well-being, the Chinese general health questionnaire, the Chinese state anxiety inventory, and the inventory of socially supportive behaviours Data were analysed by means of multiple regression analysis
controlling for psychological outcome variables at time 1. Moderating effects of sociotropy autonomy were investigated by examining the significance of the interactions of SAS and social support. The results show that whereas perceived availability of social support contributes to the prediction of psychological well-being of the sociotropic individuals, the availability is not significant or even inimical to those autonomous individuals. The effect holds regardless of the nature of social support (i.e., whether they are emotion focused or problem focused). The findings further suggest the importance of sociotropy autonomy personality dimensions. Implications for social support intervention are discussed.

Krause (1997) assessed the relationship among received support, anticipated support, social class, and mortality. Anticipated support is defined as the belief that significant others will provide assistance in the future should the need arise. Data from a prospective nation-wide survey of 60 yrs olds and older in England, Scotland and Wales indicate that greater received support is associated with an increased mortality risk. The findings further suggest that anticipated support is associated with lower mortality risk, but these beneficial effects are evident only in the upper social class. Finally, the analysis suggests that there may be a reciprocal relationship between received support and anticipated.
Bosworth and Schaie (1997) examined the relation of social networks and perceived social environment (PSE) to health outcomes and cost utilization over 1 year in a community sample of 387 Ss (aged 36-82 yrs). Two analytical strategies, a variable oriented approach and a subject-oriented approach, were used to complement each other: Structural equation modeling assessed that direct relationship between social relationship patterns were related to health outcomes. Married individuals with low levels of social networks had increased total health care costs, outpatient costs, and primary care visits. Members of the cluster groups with greater health problems were more likely to be isolated, had the least social contact, and had lower levels of education and income.

Chou (1999) examined the relationship between social support and 3 measures of subjective well-being depressive symptomatology, negative affect, and positive affect, among 475 Hong Kong Chinese young adults (aged 16-19yr). Measure completed by the SS included the center for Epidemiological studies, depression scale and the multidimensional scale of perceived social support. Significant bivariate relationships were found between positive affect and all dimensions of social support (including social network size, social contact frequency, satisfaction with social support, instrumental support, and helping
others), except composition of social network. Helping others variables and relationship satisfaction variables were negatively related to both depressive symptoms and negative affect. Multiple regression models revealed that satisfaction with relationship with family members and friends were consistently associated with all measures of subjective well-being and numbers of friends felt close to was positively related to positive affect.

Walen and Lachman (2000) Examined the (1) association of social support and strain with psychological well-being and health (2) investigate whether these associations dependent on relationship type (Father, family, friend). (3) examined the buffering effects of support on strain (both with in and across relationship type) and (4) test the extent to which these associations differed by age and sex. 2,348 adults aged (25-75 years) who were married or cohabiting participated in the study. Positive and negative social exchanges were more strongly to psychological well-being than to health. For both Sexes, partner support and strain and family support were predictive of well-being measures. Partner strain was also predictive of well-being and health outcomes more often for women. Authors find that supportive networks could buffer the detrimental effects of strained interactions, friends and family served a buffering role more often for women than for men. These results suggest that
future research consider the effects of strain and how support and strain interact, differentiate among sources of support and strain and explore variations by age and sex.

Savelkoul, Post, de witte and vanden (2000) examined the relationship between Social support, coping and subjective well being by testing three hypothesis: (1) Social support influences subjective well-being via coping, (2) Coping influences subjective well-being via social support, (3) there is a reciprocal relationship between social support and coping and both concepts influence subjective well-being. Data were analysed from 628 patient with one or more chronic rheumatic disorders (5) affecting the joints, in some patients combined with another rheumatic disease (no fibromyalgia). Although causal inferences are not possible, the results present a plausible causal sequence in supporting the second hypothesis. This is only true, however, for coping by awaiting/avoidance led to less social support and this decreases in social support influences subjective well-being negatively.

Edwards, Hershberger, Russell and Markert (2001) examined the unique contributions of positive social support and negative social exchange in the relationship between stress and health symptoms, using data from 206 undergraduates at a large state university. Negative social exchanges accounted for more variance in physical health symptoms than did life-event stress, daily
hassles, or social support. The relationship between negative social interaction and physical symptoms was not the result of variance shared with psychological well-being. The importance of attending to negative aspects of social interaction among university students in terms of their health and well-being is discussed.

Lutz and Lakey (2001) examined that social support and other social judgments are composed of several distinct components, of which relationship effects are an important part. With regard to support judgements, relationship effects refer to the fact that when judging the same targets, people differ systematically in whom they see as supportive. One explanation for this effect is that people differ in how they combine information about targets to judge supportiveness. Participants rated the supportiveness of hypothetical targets and targets from their social networks. Multilevel modeling identified the traits participants used to make support judgements. There were significant differences in the extent to which participants used different target personality traits to judge supportiveness. In addition, participant neuroticism predicted the extent to which participants used target neuroticism and agreeableness to judge supportiveness.
Tseng and Wang (2001) investigated subjectively perceived quality of life and related factors of elderly nursing home residents. 161 nursing home residents (aged 65-96 yrs) completed rating scales concerning quality of life, health status, social support and family interaction frequency. Results show of residence in the nursing home was significantly negative relative to the quality of life. Physical function, activities of daily living, social support from nurses, social support from nursing aids, social support from families, and frequency of family interaction were significantly positive relative to the quality of life. Activities of daily living, social support from nursing aids, socio economic status, physical function, and frequency of interaction with family were found to be significant predictors of quality of life.

Taylor, Chatters, Hardison and Riley (2001) examined the influence of sociodemographic and family, friendship, fictive kin, Church, and neighbour network variables on two measures of subjective well-being (i.e. life satisfaction and happiness ) among national sample of African Americans. The analyses were conducted on the national survey of Black Americans, a National Cross-Section study of the adult (age 18 and older). Black population (n=2,107). Sociodemographic (i.e. age, income, region, health, marital status, urbanicity) and social relations and network factors (i.e., subjective family closeness, support from family;
number of friends, presence of fictive kin, Church attendance and frequency of contact with neighbors) were significantly associated with subjective well-being. The findings are discussed in relation to previous work on the sociodemographic, health and social network correlates of subjective well-being.

Olstad, Sexton and Sgaard (2001) examined whether the buffer hypothesis (social support or social network may affect mental health by buffering the negative effect of stress on mental health) was tested in 3-population based health surveys which took place in 1987, 1990 and 1993 in 5 coastal municipalities in Finnmark, Norway. All persons ages 40-62 yrs and a random sample of those aged 20-39 yrs were invited, and 77%, 74% and 70% attended the 3 health surveys, respectively. Stress was divided into acute stress, and chronic stress (having a chronic disease, disability pension, being a single percent or providing long term nursing care for someone in the family) when all possible stressors and the sum of social network/social support/network buffered the deteriorating effect of total stressor score upon mental health.

Schronder and Schwarzer (2001) examined the effects of personal resources of both heart patients and their close social partners on patients coping and quality of life. Generalized personal resources (self-efficacy beliefs, dispositional optimism,
self regulation competence) and outcomes were assessed by questionnaire 1-3 days before surgery (n=122) and again 6 mo later (n=50) outcomes variables were coping style, social resources (Social support and social integration), emotional states and further measures of quality of life. Patients personal resources were dominant in the prediction of most of the outcomes. Partners resources were uniquely related to social support, social integration, and quality of life as perceived by the patients. Further, partners personality resources predicted change in patients loneliness and energy levels during the 6-mo interval.

Halleraker, Arefjord, Havik and Mieland (2001) examined the relationship between quantitative and qualitative indicator of social support and anxiety, depression and use of health services in a sample of 37 wives of myocardial infraction (MI) patients. Ina prospective design, the wives were interviewed during the acute phases of the illness, three months and 10 years post index MI. Congruent with previous research, the quantitative aspect of social support, defined as a number of persons giving help, was unrelated to adjustment, whereas, qualitative aspect of social support, defined as the wives dissatisfaction with social support, was associated with depression and use of health services. The observed association indicated, however, on effect in the opposite direction of the social support model. The findings were
unexpected and may be due to small sample.

Bohachick, Taylor Sercika, Reader et al. (2002) examined the influence of psychosocial resources of psychological recovery after heart transplantation. 28 patients were surveyed during their hospitalization after transplant surgery and 6 months post transplantation. Scales from coping with serious illness battery were used to measure psychosocial resources (Social support and Personal Control and Psychological and Functional outcomes. Psychosocial resources assessed during hospitalization were associated with recovery outcomes at 6 months post transplantation. Personal control was positively correlated with recovery outcomes at 6 months transplantation. Personal control was positively correlated with optimism well-being, and satisfaction with life ($r=0.41$ to $1.49$) and negatively correlated with anger ($r=-0.57$) and depression ($r=-0.52$). Social support network helpfulness and attachment with others were correlated with psychological outcomes ($r=0.41-.59$) and functional outcome ($r=0.42-.47$). Efforts directed towards enhancing perceptions of personal control, social support network helpfulness, and attachment may be useful for promoting psychosocial recovery.

Letvak (2002) examined that social support has been found to have a direct effect on well being of families and individuals. The mentally ill are considered to be vulnerable as a group, those
who are mentally ill and reside in rural communities are at a greater disadvantage due to limited cures to health care. Specific strategies are presented which will assist rural health nurses in providing support symptoms necessary to help rural residents in managing and coping with stress and mental health problems.

De Groot (2002) examined roll of social support for cancer patients, given the high level of distress typically associated with the diagnosis and the treatment of cancer. Social support has been described as comprised of components that are informational, instrumental, emotional, affirmation, and appraisal. Although these elements may overlap, adequate assessment of the various dimensions will ensure that appropriate clinical applications can be drawn from research findings. Gender, age, marital status, and education, may influence social support needs and social network size and the perceived adequacy of social support for cancer patients, as well as for parent caregivers of married cancer patients in relation to depression and health related quality of life.

Gleeson, Bernal and Woolley (2002) examined the composition of the support network, the type of assistance needed, the degree of satisfaction with support received, and the relationship between social support and diabetes self-management. Overall, the Ss had fairly large networks, composed primarily of family members. Ss were least satisfied with the help they
received for diabetes-related self-care, and financial assistance-
social support was not strongly related to a diabetes self-
management. The authors advise community health nurses to
provide education and resources for support persons and carefully
evaluate the support network, not only for availability, but also for
satisfaction. Efforts should be directed toward developing
alternative support for those without available family.

Jou and Fukada (2002) examined the effects of reciprocity
and sufficiency of social support on the mental and physical health
of 488 Japanese University students with different levels of
stressors. The questionnaire included items that measured support
provided for, request by, requested of and received from others. It
also addressed negative affect associated with support
relationships, as well as the levels of stressors, and mental and
physical health. The participants support relationships with others
were fairly reciprocal. Although being over benefited (i.e.,
receiving more support than one provides) was selected to stronger
feelings of indebtedness, being over benefited (i.e., providing
more support than one receives) was related to stronger feelings of
burden. In sum, when the participants receive less support than
they requested and when they provided less support than others
requested, they tended to be come less mentally and physically
healthy. Reciprocity of support appeared to have both direct and
buffering effects., however, the effects of sufficient support on health did not vary with levels of stressors.

Hogan, Linden and Najarian (2002) examined that presence of support has repeatedly been linked to good long-term health outcomes based on demonstrations of better immune function, lower blood pressure and reduced mortality. Using a computerized search strategy, 100 studies that evaluated the efficacy of such interventions were located. For the purpose of the review and evaluation; studies were subdivided into groups vs. individual interventions, professionally led vs. peer provided treatment, and intervention where an increase of network size or perceived support was the primary target vs. those where building social skills was the focus. On the whole, this review provided some support for the overall usefulness of social support interventions.

Nezlek, Richardson, Gran, Schatten and Elizabeth (2002) examined a sample of 113 healthy older adults (mean age 71.2 yrs.) used a variant for the Rochester interaction record to describe the social interactions they had each day for two weeks. They also completed various measures of psychological well being (the life satisfaction index A, the satisfaction with life scale, the UCLA loneliness scale, and the emotional and social loneliness scale). A series of multilevel random coefficient analyses found that life satisfaction scores were positively related to how
enjoyable interactions were, how self-assured people felt when interacting, how much control they felt they had over interactions, how responsive others were to their needs, and how socially active they were. Analyses that took participants marital status into account suggested, however that interaction outcomes and life satisfaction were related only for married participants, and that these relationships were primarily due to interaction outcomes with spouses.

PSYCHOSOCIAL CORRELATES OF BRONCHIAL ASTHMA:

Kulshrestha, Khan, Siddiqui, Bhargaw and Khan (1992) examined 100 families registered at Urban Health Training Centre (UHTC) of community medicine and T.B. and Chest O.P.D. within hospital from 1.7.92 to 30.9.92. Patients were thoroughly questioned. Psychological and Social profile was also studied. Out of 1000 families total patients were 176 and 102 O.P.D. patients were also included. The correlation of Bronchial Asthma was found significantly in low socio-economic status and dusty environment. Among psychological profile, death in family, loss of Job, change of house job, quarrel, affected bronchial asthma in the same decreasing order.

Rietveld, Beest and Everaerd (2000) examined the hypothesis that stress induces breathlessness and not airway obstruction. Stress was induced by a frustrating computer task in
30 adolescents with asthma and 20 normal controls, aged 14-19 years. Stress measures were self-reported emotions, heart rate and blood pressure. Respiratory measures were respiratory rate (RR), end tidal CO$_2$, deep inspirations signs asthma measures were lung function, wheeze, cough and breathlessness. All measures confirmed high levels of negative emotions and stress. None of the participants developed airways obstruction, they had no reduction in lung function. Wheeze was absent and cough negligible. However breathlessness increased in all participants with asthma and excessively in many. The mean breathlessness was higher then during induction of actual airways obstruction with provocative agents in previous studies. End tidal CO$_2$ showed that breathlessness could not be explained by hypocapnia. The authors conclude that stress can be sufficient to induce breathlessness in patients with asthma.

Grant, Lyttle and Weiss (2000) examined the relations between socioeconomic, factors and race/ethnicity as risk factors for asthma mortality. A cross sectional study was conducted by US mortality records from 1991 through 1996. Higher standardized mortality ratio were seen for Black vs Whites (3.34 vs 0.65) low vs high educational level (1.51 vs 0.69) and Low vs high income (1.46 vs 0.71 vas 0.69). Excess mortality for Blacks vs Whites was present in the highest and lowest quintiles of median county
income and educational level. The disparity in asthma mortality rates according to median county income and education remained after control for race/ethnicity. Results indicated that Black race/ethnicity appears to be associated, independently from low income and low education, with an elevated risk for asthma mortality.

**PREVALENCE OF BRONCHIAL ASTHMA:**

Shah, Mehrotra and Dhar (1994) examined data of Bronchial Asthma in patients admitted in Bombay Hospital. They stated that Bronchial Asthma is a clinical syndrome characterized by paroxysmal dysphoea and wheeze due to increased resistance to the flow of air through narrowed bronchi brought about by spasm of bronchial smooth muscle. Case sheets of 200 in patients diagnosed as bronchial Asthma under ICD code 493 were analyzed. Prevalence was found to be 0.9% of total admissions. 19 were smokers, 12 gave family history of Asthma. 164 were Hindus, 20 were Christians and 15 Muslims. Majorities were suffering from Cardio-Vascular, central nervous system and gastrointestinal tract disorders as well as diabetes as associated disease either as past illness or affected subsequently.

Khan, Roy, Christopher and Cherian (2002) examined that the prevalence of self-reported Bronchial Asthma, and related disorders in Vellore in South India. Asthma and related disorders reported to be rare in poor and developing countries and their
prevalence is expected to rise with urbanization. Investigation was carried out by using a simple questionnaire-based data collection. The subjects were employees belonging to a particular nationalized bank. A significant number of subjects with symptoms suggestive of asthma self reported themselves as non-asthmatic. There was a significant association between those who had symptoms of asthma.

**HYPERTENSION PREVALENCE:**

Goel, Singh and Kaur (1992) designed a case control study. The study was carried out in 6 villages of Chirai gao block, from July 1992 to Nov, 1992; out of which 117 cases were diagnosed as hypertensive giving an overall prevalence rate of 7.94% (5.332%) in males and 9.59% in females). Two controls, age and sex matched, were selected against one case. Various risk factors like- Socio-economic status, Obesity, Smoking habits, tobacco chewing habits, alcohol addiction in general and dietary intake in particular were studied in detail.

Gupta and Gupta (1999) examined the prevalence of hypertension and blood pressure trends in a large population in Metropolis. They conducted a house-to-house survey in South Mumbai. A total of 99, 598 individuals were studied. Analyzable data were available in 99, 589 subjects., 40,067 (40.2%) males and 59,522 (59.8%) females., 625 (1.56%) males and 1574(2.64%)
females were aware of the presence of hypertension. There were increases in the mean systolic as well as diastolic BP with age (P<0.001). As compared to females, the mean systolic BP was mere in males under 40 years of age, after this age the systolic BP was greater in females. According to JNC-VI guidelines hypertension prevalence was 43.8% in males and 44.5% in females. There was a significant increase in the prevalence of hypertension with age. The prevalence of mild hypertension (stage I) was more at younger age groups and decreased with age while stage II hypertension increased and the prevalence of stage III and IV hypertension remained relatively constant. There is a higher prevalence of hypertension in Urban adults of Mumbai than reported in studies from North Indian cities of Jaipur and Delhi.

National Institute of Health, Lung, and Blood Institute, National High Blood Pressure Education Programme (1999) identifying and treating high blood pressure to reduce the risk of cardio-vascular disease and associated morbidity and mortality. The positive relationship between SBP and DBP and cardiovascular risk has long been recognized. This relationship is strong, continuous, graded, consistent, independent, predictive, and aetiologically significant for those with and without coronary heart disease.
Varma, Swaminathan, Das, Kumar, Balachander (2000). Established a programme with the aim of screening patients 45 years or more of age, attending OPD in our hospital for hypertension. One thousand consecutive South Indian, drug naïve patients, 45 years and above of age, attending medicine OPD for non-cardiac complaints were screened with blood pressure measurements, using standard procedure by a single observer. Hypertension was detected in 141 (14.1%) patients. Combined hypertension was present in 86 (8.6%) patients, isolated systolic hypertension in 29 (2.9%), isolated diastolic hypertension in 24 (2.1%) and secondary systolic hypertension in 5 (0.5%) pseudohypertension was detected in 25 (2.5%) and White Coat hypertension in 23 (2.4%) patients. Male patients had significantly higher mean systolic blood pressure, diastolic blood pressure, pulse pressure and mean arterial pressure as compared to female patients. The occurrence of isolated systolic hypertension and pseudohypertension increased with age. While systolic blood pressure showed an increase with age, there was no significant variation in diastolic blood pressure with age. True isolated systolic hypertension formed only 34.8 percent of the total number of patients (83) with isolated elevation of systolic blood pressure. These results indicate a wide prevalence of hitherto undetected hypertension among patients visiting a general OPD. Active
screening for hypertension among people older than 45 years is imperative at the community level to detect the disease at an early stage and thereby reduce the associated morbidity and mortality.

Arya (2000) has identified that the cut off age for elderly person is India 60-65 years, in the USA is 75-80 years. Elderly people may have (i) systolic - diastolic hypertension, (ii) isolated systolic hypertension or (iii) pseudo-hypertension. The number of elderlies in 1990 was around 60 millions and by 2020 nearly 10% of population is likely to be above 60 years. Hypertension (HTN) is likely to be detected in 30-40% of those persons. Hypertension is present in 18% rural and 40% in urban elderlies. The 6th Joint Committee on Detection, Evaluation and Treatment of High Blood Pressure (JNC-VI) has identified age above 60 years as an independent risk factor for hypertension.

Chabra, Lal and Sharma (2001) examined the status of lifestyle modifications in hypertension. The prevalence of hypertension in India ranged between 16.89% and 23.7% in rural and between 30% and 33% in urban areas. As regarding dietary interventions, caloric restriction may influence the minimization of BP. Body weight reduction, less alcohol consumption, salt restriction; Potassium and Calcium supplementation can enhance the process of lowering BP. As regarding behavioural changes, stopping smoking, regular physical
exercise, relaxation therapies like Yoga, etc, have definite beneficial effect on hypertensives.

Ahlawat, Singh, Kumar, Kumari and Sharma (2002) examined the changes in the prevalence of hypertension and associated risk factors over a 30 years period a cross-sectional population survey in three randomly selected sectors of Chandigarh city. Study population consisted of 1181 individuals (570 males and 611 females) aged 35 years and above. A total of 1049 subjects were interviewed using a structural interview Schedule, and 937 were examined by a Physician. Blood pressure and anthropometric measurements were recorded. Age and sex standardized prevalence of hypertension according to JNC-V criteria increased from 26.9 percent in 1968 to 44.9 percent in 1996-97. In 1968, 70% of the male population were engaged in sedentary and light physical activity compared to 73.7 percent in 1996-97. High and high middle-income groups in males were 61.2% in 1996-97 compared to 37.4% in 1968. Smoking rates, however, remained unchanged, 25.4 percent men smoked in 1968 compared to 24.6 percent in 1996-97. The prevalence of hypertension has almost doubled over 30 years in Chandigarh. Unfavourable changes in prevalence of hypertension physical activity, and body fat makes this population highly vulnerable to Cardiovascular morbidity and mortality.
Shanthirani, Pradeepa, Deepa, Premalatha, Suroja and Mohan (2003) examined the prevalence of hypertension and its associated risk factors in an urban South Indian population at Chennai. The Chennai urban population study (CUPS) is an epidemiological study involving two residential areas in Chennai in South India. 1399 eligible subjects (age ≥ 20 years), 1262 (90.2%) participated in the study, subjects were classified as hypertensive using the criteria, systolic blood pressure (SBP) ≥ 140 mm Hg, and / or diastolic blood pressure (DBP) ≥ 90 mm Hg and / or treatment with anti-hypertensive drugs. Twelve-lead resting electrocardiography (ECG) was performed in 1175 individuals and peripheral Doppler studies were done in 50% of the individuals (n=631). Results indicated that prevalence of hypertension appears to be high in this urban south Indian population and this calls for urgent steps for its prevention and control

**PSYCHOSOCIAL CORRELATES OF HYPERTENSION:**

Ghosh and Sharma (1998) examined the role of anxiety and anger in essential hypertension and surgical orthopaedic patients (n=40 each), by administering the Hindi version of Spielbergers t-anxiety scale of STAI and anger expression (ax) scale in clinical setting. Patients of both groups i.e, E.H and surgical/orthopaedic were male, married outpatients with mean age of 46.53 and 40.38 years respectively. These patients had urban middle class
background, a minimum of high school education and no other secondary complications. The findings are when compared to the surgical /orthopaedic controls, EH patients reported not only higher trait anxiety but also higher frequency of anger regardless of the direction of anger expression. When dimensions of anger were considered .EH patients reported higher active suppression of angry feelings than their surgical/ortho counterparts. However, no significance difference was observed on aggressive behavior direct towards other people or object in the environment. This study highlights the association of negative emotions (anxiety and anger).

Sehgal (2000) examined the role of anger, anxiety, hostility, irritability and type A behaviour pattern in Essential Hypertension (EHT) and Coronary Heart Disease (CHD). Three groups of subjects (hundred each) belonging to the above-motioned groups i.e., EHT, CHD, plus a healthy group were included as subjects. Standard internationally recognized instruments were used and the earlier work was thoroughly surveyed so that a cross-cultural prospective could be evolved.

Mulli, Stieber, Wickmonn, Koenig and Peters (2001) Examined the association between blood pressure, meteorology, and air pollution in a random population sample. Blood pressure measurements of 2607 men and women aged 25 to 64 years who
participated in the Augsburg Monitoring of Trends and Determinants in Cardio Vascular Disease survey were analyzed in association with 24- hour mean concentrations of air pollutants. Continuous concentrations of total suspended particulates and sulfur dioxide were associated with an increase in systolic blood of 1.79 mm Hg (95% confidence interval) (CI)=0.63, 2.95 per 90 ug/m$^3$ total suspended particulates and 0.74 mm Hg (95% CI=0.08, 1.40) per 80 ug/m$^3$ Sulfur dioxide. In subgroups with high plasma viscosity levels and increased heart rates, systolic blood pressure increased by 6.93 mm Hg (95% CI=4.31, 9.75) and 7.76 mm Hg (95% CI=5.70, 9.82) in association with total suspended particulates. The observed increase in systolic blood pressure associated with ambient air pollution could be related to a change in cardiovascular autonomic control.

Sande et al (2001) questioned 5389 adults as to any first degree family history of non-communicable diseases (hypertension, obesity, diabetes and stroke), and measured their blood pressure (BP) and Body Mass Index (BMI). Total blood cholesterol, triglyceride, uric acid, and creatinine concentrations were measured in a stratified sub sample as well as blood glucose in persons aged >35 years. A significant number of subjects reported a family history of hypertension (8.0%), obesity (5.4%) diabetes (3.3%) and stroke (14%), with 14.6% of
participants reporting any of those NCAS. Subjects with a family history of hypertension had a higher diastolic BP and BMI, higher cholesterol and uric acid concentrations, and on increased risk of Obesity. Results show that family history of hypertension, Obesity, diabetes, or stroke was a significant risk factor for Obesity and hyperlipidaemia with increase of age, more pathological manifestations can develop in this high risk group.

Light (2002) comments on the article by D. Carroll et al, which presented results of the 2nd phase of a prospective study examining BP reactivity to a mental stressor in middle aged men as a predictor of subsequent BP level and hypertension development. The framework for the study was provided by the Classic Reactivity Hypothesis. K.C. Light suggested that it is time for this hypothesis to reflect its advancing maturity and yield its place to the next generation. One of the Labeled the Gene and Environment Modulated Reactivity Hypothesis, assumes that there is substantial plasticity in the relationship between genetic factors and hypertension development.

Krause, Liang, Shaw, Sugisawa et al, (2002) examined whether three dimensions of religion (private religious practices, religious coping, and belief in the afterlife) buffer the effect of death of a significant other on change in self-reported hypertension over time. Interviews were conducted with a
nationally representative sample of people aged 60 and older in Japan at two points in time, 1996 and 1999. Complete data were available on 1,723 older Japanese (average age 69.17 yrs). Respondents were asked a series of questions about their religious belief and practices, whether a family member or close friend had died in the past year, and whether they had hypertension. The data suggest that older adults in Japan who experienced the death of a loved one but who believe in a good after life were less likely to report that they had hypertension at the follow up interview that elderly people in Japan who lost a close other but did not believe in good after life. The results suggest how one over looked dimension of religion (i.e., religious beliefs) may bolster the health of older people in the face of adversity.

Davidson, Schwartz, Sheffield, McCord et al (2002) discussed the cognitive and emotional processes that link emotional expression to blood pressure. They present preliminary data relating expressive writing to reductions in blood pressure. Finally, they discuss the potential benefits of expressive writing for patients with high blood pressure and future research directions.

Yadav, Siwach, Sharma, Yadav and Aggarwal (2002) examined 108 patients (67 males 41 females). Detailed history was taken. In 82 patient who were young hypertensives and had no
other clinical criteria for inclusion in the study, only 15 patients (18.3%) showed evidence of renal disease by radiological and imaging studies. 26 patients who had some other clinical criteria in addition to hypertension showed evidence of renal or renovascular disease in 17 patients, showing an increase of 47.1% as compared to those patients who had only hypertension. Thirteen out of these 26 patients had 2 or more than 2 clinical criteria; renal or renovascular changes being found in 12 patients (92.3%). Weinberger had found that all but 2% of hypertensive patients with abnormal bruit had subsequently been proved to be having renovascular hypertension.

HYPERTENSION MANAGEMENT:

Blumenthal, Sherwood, Gullette, Georgia des et al (2002) reviewed the current approaches to the non-pharmacological treatment of high blood pressure and highlights outcomes studies of exercise, weight loss, and dietary modification, and stress management and relaxation therapies. Methodological issues in the assessment and treatment of hypertension are discussed, along with possible mechanisms by which life style modification may reduce elevated blood pressure.