CHAPTER-I

INTRODUCTION

1.1 Health

Health encompasses both dimensions, i.e., physical and mental health of a person’s persona. According to a the global definition of health, “health is an all embracing picture of physical, emotional and spiritual components which integrates all therapies, philosophies and traditions”. According to WHO (1948), “health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity”. This definition is still widely referred to by reports such as the Ottawa Charter for Health Promotion stated that “health is a resource for everyday life, not the objective of living. It is a positive concept emphasizing social and personal resources, as well as physical capacities.” “Generally, four general determinants of health including human biology, environment, life-style and health care services have been identified” (Altman, 1982).

Health is an outcome of the interaction between various factors. “There are various personality features, such as self-efficacy, expectancies, psychological hardiness, optimism and a sense of humor, are believed to have positive effects on our health” (Balog, 1981). Persistent stress leads to exhaustion of our capacities to cope by weakening our immune systems.

Mental health definitions are changing constantly. Earlier, it was that “a person was considered to have good mental health only if he showed no signs or symptoms of a mental illness. But in recent years, a more holistic approach to mental health has emerged”. Today, it is recognized that “good mental health is not just the absence of mental illness; rather it refers to an individual’s emotional and psychological well-being” (Baumann, 1961).
According to Merrriam Webster dictionary, mental health is “a state of emotional and psychological well-being in which an individual is able to use his cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life”. Economic realities, cultural issues, and ethnic variables are some social factors that affect our health. Social support acts as a buffer in balancing the impact of stress.

1.1.1 Narrow Perspective of Health

People with a narrow perspective consider health as the absence of disease or disability or biological dysfunction. According to this view, to call someone unhealthy or sick means there should be evidence of a particular illness. Social, emotional and psychological factors are not considered to cause unhealthy conditions (Apple, 1960). This model is narrow and limits the definition of health to the physical and physiological capabilities which are necessary to perform routine tasks (Altman, 1982). According to this definition, the individual is healthy if all his body parts, cells, tissues and organ systems are functioning well and there is no apparent dysfunction in the body. Using this model, people view the human body in the same terms as a computer, or mechanical device — when something is wrong, it is taken to experts who maintain it. Physicians, unlike behavioral experts, often focus on treatment and clinical interventions with medication rather than educational interventions to bring about behavior change.

1.1.2 Broader Perspective of Health

Physical health, one of the components of the definition of health, is defined as “the absence of diseases or disability of the body parts and as the ability to perform routine tasks without any physical restriction” (Boruchovitch, 1993). Health is not limited to the biological integrity and the physiological functioning of the human body (Kaplan, 2000). Psychological health is also an important aspect of a health definition: The mentally healthy person shows behavior that demonstrates awareness of self, who has purpose in life, a sense of self understanding, self -value and a
willingness to perceive reality and cope with life difficulties; the mentally healthy adult is hard-working, active and productive, continues with task until it is completed, logically thinks about things affecting his own health, responds flexibly in the time of stress, receives pleasure from various sources, and accepts his own limitations realistically (Fonseca, 2001). The healthy adult has a capacity to live with other people and understand other people’s needs. It is sometimes considered that the mentally healthy person shows growth and maturity in three areas: cognitive, emotional and social (Kalpan, 2000) which are discussed as follows:

The cognitive component of mental health is related to thinking and being able to work things out. It includes the ability of an individual to learn, to have awareness and to perceive reality. At a higher level it also involves having a memory and being able to reason and solve problems, as well as being able to work creatively and with a sense of imagination. The emotional component of health is the ability and skill of expressing emotions in an ‘appropriate’ way. Social component of health is considered to be the ability to make and maintain ‘acceptable’ and ‘proper’ interactions and communicate with other people within the social environment. This component also includes being able to accomplish a social role. Having a social role is the ability that people have to maintain their own identity while sharing, cooperating, communicating and enjoying the company of others. This is really important when participating in friendships and taking a full part in family and community life However, the holistic dimension of health talks about three more dimensions of health.

1.1.2.1 Physical Dimension

We have a number of physical and structural characteristics like body weight, visual ability, strength, co-ordination, endurance level etc. The physical dimension of health plays a very important role in certain situations.
Introduction

1.1.2.2 Spiritual Dimension

This dimension of health includes the religious beliefs and practices that are considered to be basic ingredients of spiritual health. This dimension of health has been given a significant place in the overall concept of health (Boamah, 2011).

1.1.2.3 Occupational Dimension

In contemporary world, employment plays a very significant role in deciding our perception about ‘self’ and about the world in which we live. Workplace also helps us hone up our skills to resolve conflict, experiences in sharing responsibility and mental growth. Consequently, workplace is expanded and designed by the individual’s health (Boamah, 2011).

1.1.3 Bio-Medical Model of Health

This model was introduced in Australia in the late 1870s. The notion considers health as merely the absence of disease, stemmed from a biomedical conceptual model of health which viewed disease primarily as a malfunction of the physical body, resulting from injury, infection, etc. (Johnston and Weinman, 1995). And, following the logic, if disease consists only of physical pathology, then health must be the state in which physical signs and symptoms are not present. Its wide acceptance was made evident by the accepted definition of health as “the absence of disease” by the World Health Organization in its initial years.

The Bio-Medical Model is based on the assumptions given below:

1. Some organic condition underlies every disease.
2. Disease is an organic state which is temporary and can be treated by means of medical intervention.
3. A ‘sick person’ experiences disease, who is referred to as the ‘object of treatment’.
4. The treatment of disease is carried out after the appearance of symptoms.

5. The treatment of disease is carried out in a medical environment.

However, the Bio-medical model was said to be a partial definition of the concept of health, deficient in social factors.

1.1.4 Social Model of Health

“The sanitary campaigns of the 19th century and much of the work of the founding fathers of modern public health reflected awareness of the powerful relationship between people's social position, their living conditions and their health outcomes” (Marmot et al., 1999). According to (Virchow, 1848, 1985), “The centrality of social and environmental factors in the major health improvements registered in industrialized countries began in the early 19th century”. According to analysis done by Mc Keown (1976), “most of the substantial modern reduction in mortality from infectious diseases such as tuberculosis took place before the development of effective medical therapies. Rather, the main driving forces behind reduction in number of deaths were changes in food supplies and living conditions”.

As per The World Health Organization Constitution, 1946 (Constitution of the World Health Organization, 1948), “the Organization's founders intended for WHO to address the social roots of health problems, as well as the challenges of delivering effective curative medical care” (WHO, 2003). The central functions of an organization include “promoting the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene”. According to WHO, “the role of public health is to promote health, prevention of disease and prolong life through the organized efforts of a society” (WHO, 1978).

As an outcome of this notion of health by WHO, a new era began in the area of public health and was named as New Public Health which refers to “an organized response by society to protect and promote health and to prevent injury, health and
disability”. As a result of this approach and rethinking of public health, another model of health took shape and it is known as the social model of health which developed in 1970s.

“The Social Model of Health aims to address the factors that lead to ill-health and health inequality within the community” (Spiegel, 2004). In the conceptual framework of the model “the improvements in health and well-being through directing effort towards addressing the social, economic and environmental determinants of health” are included.

1.1.5 Bio-Psychosocial Model of Health

It has always been apparent to physicians that the patient’s personal history and his current social circumstances all play a significant role in the onset of illness and in the interpretation of the symptoms by the patient. This depicts the Bio-Psychosocial model implicitly (Davidson Neale, 1994). The presentation of illness is an outcome of material lesions, life experiences and current social situations of the patient taken together. These implicit insights first became explicit in the era of therapeutic nihilism of the late 19th century. This time, physicians began to realize quite correctly that they could cure only on the basis of physiological knowledge and patients need to be supported with the help of psychological means. This led to the origin of Bio-Psychosocial Model of Health.

By the late 1970’s, advances in psychological, medical, and physiological research led psychiatrist George L. Engel, (Engel, 1997) to rethink on health and illness. Engel theorized a health model in which health and illness were seen as “the product of a combination of factors including biological characteristics, psychological and behavioral factors, and social conditions” (Engel, 1980). This conceptualization was labeled the Bio-Psychosocial Model and this new conceptual framework represented a paradigm shift in that health was now to be viewed from the perspective of the whole person, and not exclusively based on bodily dimension (Epstein, 2004).
**Introduction**

Defining the concept of health is not a settled matter, however, in 2000, Health Philosopher C. Brulde challenged the “traditional” concept of health. In the traditional approach, the focus was on the level of health. “A person is healthy if he feels well and can function in his social context (Frankel, 2003). Nordenfelt (2000) points out that a person can be in bad health without feeling bad, and that ill-being is not necessary for ill-health.

The Bio-Psychosocial model has enjoyed broad recognition across a varied set of fields of study in recent years. The World Health Organization has redefined and broadened its concept of health defining it now as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

‘International Classification of Functioning, Disability and Health’ (ICF) integrated a Bio-Psychosocial model. The model allowed “an examination of the impact of health conditions not only on the basis of health and disability, but also takes into account the mental and social aspects of disability” (WHO, 2002).

The concept of health is wide and the way health is defined also depends on individual perception, religious beliefs, cultural values, norms, and social class. Generally, there are different perspectives concerning people’s own definitions of health.

**1.1.6 Self-Rated Health**

Symptom attribution refers to the interpretation of specific bodily experience, In contrast, self-rated health refers to an individual's global assessments of health and has a long history in the study of health in later life. Initial research efforts in this area focused on the validity of self-rated health as a proxy for more objective indicators of health status, including physician assessment and chronic illness (Abrums, 2001). “There are strong relationships between objective health measures and self-rated health” (Fillenbaum, 1979; Tessler & Mechanic, 1978). Later on, “interest in self-rated health was triggered by evidence from numerous studies which found self-rated health is a significant predictor of mortality even when the effects of physical health,
chronic illnesses, and functional status are taken into account "(Idler & Kasl, 1991; Strawbridge & Wallhagcell, 1999).

1.1.6.1 The Meaning of Self-Rated Health

The robust relationships observed between self-rated health and various health outcomes have triggered substantial attention to its meanings and antecedents. It is one of the most easily measured concepts in the social science, typically, individuals are asked “to rate their overall health as poor, fair, good, excellent with some studies adding ‘very good’ as a fifth option”. These research traditions have contributed to our understanding of self-rated health: quantitative studies in which survey data are used to identify the antecedents of self-rated health, studies of social comparison processes in late life, and qualitative studies” (Abrums, 2001).

Three social psychological factors have also been demonstrated to predict self-rated health. First, psychological distress is strongly related to health appraisals (e.g., Okun and George, 1984; Tessler and Mechanic, 1978), although this has been largely ignored in recent studies. Second, identification of oneself as old is associated with perceptions of poorer health (Engle and Graney, 1985). Third, older adults who scored higher on bodily awareness rated their health as poorer than those who scored low on this self-attribution (Hansell and Mechanic (1991).

With the possible exception of age identity and bodily awareness, the predictors of self-rated health identified in previous research are more useful for helping us to understand who appraises their health as good and bad than for understanding why and how individuals appraise their health as they do. Both social comparisons research and qualitative studies have made the major contributions to those issues (Bisconti and Bergeman1999).

Self-rated health as an overall health measure, is becoming common around the world and is among the most frequently assessed health perception in epidemiological research. Self-rated health can be assessed by asking the participants of the study to rate their overall health on a numeric scale or by qualitative
Introduction
descriptors. For the most part, the latter has been used, typically with a five-point
Likert Scale categories like “excellent”, “very good”, “good”, “fair” or “poor”.

Cameron et al. (1993), “Historically, most of the research on self-rated health
has focused on its capacity to predict a range of health outcomes, including social-
psychological well-being, morbidity, health care utilization and mortality.”

Various studies have highlighted the physical health dimension, with studies
demonstrating that “self-rated health is closely associated with the experience of
physical symptoms, including chronic conditions, functional ability, and severity of
current illness” (Belgrave, 1990).

Two more health dimensions have also emerged to bear a potentially
important relationship with self-rated health: mental well-being and general social
health dimension. With regard to mental well-being, some significant indicators
include depression, anxiety, psychological distress and self-esteem. And, social health
measures include social functioning: the extent of social engagement and participation
in social activities etc. (Jylha, 1994).

1.2 Stress

The term ‘stress’ carries different meanings to different people. According to
Leventhal and Nerenz (1983), “A layman may define stress in terms of pressure,
tension, or an emotional response”. Recent definitions of stress consider stress as “the
sum total of biochemical, physiological, behavioral and psychological changes”. Researchers have also differentiated between distress and eustress. Also, researchers
have distinguished between ‘acute stress’ and ‘chronic stress’. Lazarus and Launier
(1978), conceptualized it as, “stress is a transaction between people and the
environment .The degree of stress they experience is measured first by their appraisal
of the event and then by their appraisal of their personal resources”. “A good person
environment fit results in no or low stress and a poor fit results in higher stress”
(Violanti et al., 1993).
Introduction

Baum and Singer, 1982, “Stress is somewhat like an air-plane which is ready for take-off; where all body systems are virtually modified to meet the perceived threat. People can experience stressors either externally or internally. Adverse physical conditions such as pain, hot and cold temperatures or stressful psychological environments such as poor working conditions or abusive relationships are some of the external stressors whereas, internal stressors can also be bodily or psychological like infections, inflammations etc.” Eg. “intense worry about the damaging event that may or may not occur” (Millstein and Irwin, 1987).

Lazarus and Folkman (1984), “Stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his well-being which emphasizes that stress refers to a ‘taxing relationship’ between the person and the environment. When a person is unable to deal with that relationship, he or she may experience a reduction in physical and psychological well-being. Stressful life-events are those external events that make adaptive demands on a person. Individuals may successfully adapt to those demands or they may not. When they fail to adapt, the end result may be physical or psychological illness or both”.

1.2.1 Stimulus-Oriented Approach

This view of stress was expressed by Symonds (1974) who said that there appears to be great individual variations in resistance to stress. Speeded information processing, environmental stimuli, perceived danger, disturbed physiological function, quarantine, restraint, blocking, group pressure and frustration have been classified as stressful situations by Weitz (1970). Perceived threat in general and threat to a person’s most important values and goals in particular have been recognized (Lazarus, 1966, 1976) as stressful events.

However, several difficulties are associated with stimulus-oriented approach. The major one is that of identifying with some surety what is stressful about particular real-life situations. In addition there is a need to quantify the degree of stress present. A further problem arises if a situation appears to be stressful because of its stimulus
Introduction

characteristics and evokes the appropriate response to stress from most but not all people.

1.2.2 Response-Oriented Approach

According to Selye (1956), “Stress is the non-specific response of the body to any demand made upon it”. Selye’s primary concern was for the physiological mechanism and this has led to a close association between response-based and physiological model of stress. There are three basic ideas built into Selye’s concept of stress. Together these represent his General Adaptation Syndrome Model of Stress. In the first phase, i.e, the alarm reaction, “the body shows the changes characteristic of initial exposure to the stressor, and at the same time, its level of resistance is reduced. If the stressor is quite strong, resistance may collapse and death results”. During the second stage, resistance and continued exposure to the stressor leads to development of adaptation. The changes in body disappear and are replaced by the changes marking the person’s adaptation to the situation. Finally, following long-term exposure to the same stressor and one to which the body has adapted, the necessary energy for adaptation may be exhausted. The sign of alarm reaction reappears as the person dies.

1.2.3 Interactional Approach

The interactional approach describes stress as “an outcome of the existence of a particular relationship between the person and his environment”. Cox and Mackay (1976) formulated, “stress can be most adequately described as part of a complex and dynamic system of transaction between the person and his environment”. This description of stress is eclectic as it considers both response and stimulus based approaches, it, however, also emphasizes “the ecological and transactional nature of the phenomenon”. McGrath (1976) has argued that “the closer perceived demand is capability and given an imbalance, then greater is the stress experienced”.

Stress experienced is ‘an inverted U-shaped’ function of the imbalance between perceived demand and perceived capability. Lazarus (1976) has presented
Introduction

essentially an interactional definition of stress, “stress occurs when there are demands on the person, which tax and exceed his adjustment resources”. He has emphasized that “stress is not simply out there in the environment, that it depends not only on external conditions but also on constitutional vulnerability of the person and the adequacy of his cognitive defense mechanism”. Lazarus draws particular attention to “how a person appraises hi situation, and the role of frustration and conflict, in of threat in producing that stress”.

1.2.4 Symptoms of Stress

1.2.4.1 Physical symptoms

Headaches, shivering eyelid and nose, jaw and facial pain, difficulty in eating and drinking, oral-ulcers, neck pain, giddiness, vocal difficulties, muscle- ache, digestive problems, stomach- ache, sexual incompetence, sleep disorder, high B.P. and acidity.

1.2.4.2 Emotional symptoms

Short tempered nature, mood swings, depression, aggressiveness, memory loss, night-mares, withdrawal, anxious behavior, resentment, suicidal ideation, feeling of helplessness, unrepressed behavior, uneasiness, indecisiveness, lack in sexual activity, confused mind state, disturbed thoughts, anxiety and panic attacks (Billings and Moos, 1982).

1.2.4.3 Behavioral symptoms

Lines on forehead, high pitched voice, heavy eating, lack of interest in physical appearance, compulsive starvation, chronic hesitation, sudden change of social behavior, chronic delay in performing tasks etc. (Billings and Moos, 1982).

1.2.5 Workplace Stress

Taber's Cyclopedic Medical Dictionary (2005), “stress is the result produced when a structure, system or organism is acted upon by forces that disrupt equilibrium
or produce strain”. “Workplace stress” results in damaging physical and emotional response which is an outcome of a combination of high demands in a job and a lesser control over the situation.

“Job stress” refers to the stress which stems from one’s work. The operational area of such forces or stimuli would be limited to the organizational boundaries of stress to qualify as “Job Stress”. According to Jackson and Schuler (1985), the varied model that has been developed so far has tended to take partial or single perspective on the concept of stress and has suffered as consequence. Orphan (1995), “the major source of stress is derived from the occupational environment”. Advocates of this view argue that people in certain occupations are much more likely to experience stress, irrespective of individual differences, in as much as they are exposed to such job aspects as role-overload, role-conflict, physical harm and noxious chemicals that are absent in other occupations.

The second perspective focuses on the reactions of individuals to the objective demands of the job. In this perspective, individuals are perceived as differentiating in their susceptibility to stress, regardless of their occupational levels. According to Beehr and Bhagat (1985), McGrath (1976), an employee will perceive any occupational situation as stressful irrespective of its objective attributes, provided he or she perceives its demands as exceeding or threatening to exceed the individual’s felt capacity to cope with it. It is emphasized that what counts is how the situation is perceived. There are virtually no limits on what different individuals will perceive as threatening to exceed or actually exceeding their capabilities. It is a perspective which is sympathetic to the view that inherent personality attributes need to be invoked to explain the amount of stress a person experiences.

Workplace stress can be a result of many reasons or may be an outcome of a single event. It can affect both, employees and employers in the same way. According to Canadian Mental Health Association (2000), “fear of job loss, increased demands for overtime due to dearth of staff and layoffs due to an uncertain economy act as negative stressors. Employees under the “pressure to perform” can feel negatively
Introduction

affected due to enhanced effort to meet increasing expectations with stagnation in job satisfaction. The unrelenting demand to work at optimum level of performance results in job dissatisfaction, low employee turnover, decreased efficiency, illness and sometimes even in death”. Absenteeism, illness, alcohol abuse, “petty internal politics”, inefficient decisions, indifference and apathy, lack of motivation etc., are all an outcome of an over stressed workplace.

Causes of work place stress

Some of the most obvious causes of workplace stress include “job insecurity, technology, work culture, high demand for performance, personal or family problems etc.”. Occupational stress may become chronic due to that it affects a major part of daily life. Stress, in turn, “affects a worker's effectiveness by affecting concentration, causing sleeplessness and weakened immunity, back problems, accidents and loss” (Cox and Cox, 1993). Job stress can result in harassment or even violence during the job. In the worst case, stress puts pressure on the heart and circulation can be fatal. According to Canadian Mental Health Association (2000), some of the grave stressors at work place are described as below:

Ineffective decision-making, unrealistic performance demands, lack of effective communication and methods of conflict-resolution among workers and employers, lack of job security, long working hours, office politics and conflicts among workers, underpaid in terms of wages with levels of responsibility, insufficient equipment, training workplace politics, harassment at work place and so on.

1.2.6 Police Stress

There is no occupation that remains shielded from the reach of stress. There exists some degree of occupational stress in every organization at various hierarchical levels. Police organization is also not cushioned from this reality. Aakster (1974), “For long, it has been assumed that police work is the world’s most stressful occupation. The police service involves the highest level of stress and maximum aftermaths”. Policing is seen as an occupation that has been identified with the highest
stress levels. Duties of police personnel are varied and may differ from one another. General duties of police constables involve maintaining law and order, peace keeping, protection of masses and properties, and investigating and interrogating crimes. They have to meet the unexpected situations arising during their duty.

Fennel (1981) described policing as “the most dangerous job in the world emotionally”. Axelbred and Valle (1978) concluded that “police work has been identified as the most psychologically dangerous job in the world”. Somodaville (1978) proclaimed that “it is an accepted fact that a police officer is under stress and pressure unequalled by any other occupation”.

In an empirical study conducted by Kroes and Gould (1979) on job stress in policemen, they found that “administrative lack of support is a much more vigorous stress category than originally expected”. The argument that “policing is extremely stressful has come in agreement with agenda of assumed stressors and lists of undesirable scores outcomes. On the job threat, violence or the potential of violence and danger-has topped most lists of anticipated stressor”.

As one officer observed, “the most stressful call is the one that summons you to headquarters” (Smith, 1982). Brown and Campbell (1994) reported that “on asking police themselves to list significant causes of stress they mentioned the same occupational traits which are linked with stress in the working lives of other types of employees”.

“Poor and insensitive supervision, troublesome workload, work shifts, issues of personal safety and immense paperwork have been listed as the most significant sources of stress at work by officers from both the United States and United Kingdom” (Kroes, 1982; Brown and Campbell, 1990). The report labeled ‘Stress in the Police Service’ (Association of Chief Police Officers, 1984) suggested that stress could be mostly perceived as an outcome of management and organizational factors. From their review of research studies, Molloy and Mays (1984) concluded that “policing is probably stressful for reasons quite different from those typically
presented in the literature”. Molloy (1984) further quoted that “it seems that helplessness and feelings of uncontrollability in the work environment may be a major source of stress for police officers”.

Yadav (1994) reported that police personnel under training have lesser scores on the global measure of stress as well as on other measures of emotional problems than police personnel who have served for sufficient period of time. This shows an obvious relationship between stress and emotional problems. In an empirical study by Mathur (1994) on stressors and coping responses among police personnel, he suggested that a majority of the subjects have been affected by workplace stress. Singh and Mohan (1997) have concluded that there is a notable degree of psychological stress existing among Punjab police personnel and this is adversely affecting their professional, physical and psychological well-being.

Kalia (1995), “The physical danger involved in policing puts them in a state of continuous conflict between their instinctual tendency to avoid damage and their duty to handle the challenges. Their continuous observation of incidents of injury and death only acts to reinforce this conflict”.

Kirschman (1997) observed that most outside observers think that police is all-powerful which is right in some senses. Still officers “experience the terrible dilemma of being simultaneously powerful and powerless”. Thinking about stress makes officers feel that they are “constantly scrutinized, supervised, and reined in by their own department and by the community in ways that can be irritating, humiliating and sometimes irrelevant to their actual performance”.

Ellison and Genz (1978) reported that “job stressors result in long-term dissatisfaction which originate in random incidents, such as those involving serious cases of child abuse or the death of a fellow officer in duty. Such encounters, are sometimes called as critical incidents”. Lewis (1973) reported that “in one municipal police department, officers came across three injured adults a month, a fatal bleeding
every trimester, an injured child every two months, a serious assault victim every two months, and a dead body every three months”.

“Because of work stress, police officers are experiencing interpersonal relationship problems” (Buker et al., 2007). “Those who fulfill a helping role during or after traumatic events”, have been labeled in critical occupations by Paton and Smith (1999). Selye (1999) noted that “due to the inherent nature of police work, this profession is likely to be one of the most stressful occupations in the world”. Lewis (2000), referred to the dangers associated with the occupation as “danger stress” due to the characteristics and the nature of policing. “The hazard and trauma related with policing profession, therefore, differentiates police work from other occupations” (Coman et al., 1991). Selye (1999), “the reactions of police officers are classified as physiological, emotional and behavioral. Bodily reactions may be termed as ‘having higher probability of death than death’, specifically, multiple health problems. However, emotional reactions may include depression and in extreme cases suicide. Emotional reactions, sometimes, may be termed as Post-Traumatic Stress Disorder (PSTD) due to their severity”.

According to Gul et al. (2008), “work environment is one of the sources of police stress which can be internal as well as external. Internal work environment includes factors related to organizational structure”. Organizational climate can be a great cause of stress for police officers. “Factors like the shift schedules, poor interpersonal-relationships with supervisors, inter-departmental politics, lack of promotion and transfer opportunities, lack of autonomy in performing duties and lack of recognition for work accomplishments are among the organizational stressors faced by members of the police force”.

“Police officers play a vital role in maintaining law and order in the society despite all the limitations in the police department, majorly those which concern the infrastructural facilities, and workforce shortages” (Jackson and Christina, 1982). According to Havassy and Victor, 1994, “Police officers are at high risk of experiencing exposure to psychologically straining situations and potentially psycho-
traumatic experiences”. Another is the phenomenon of “Burst Stress” which means that there is no constant stressor. Police officers face many dangers in their jobs which are not stressful initially. W. Clinton Terry (1985) drew attention to the phenomenon of “Burst Stress”, who also coined the term “Police Stress Syndrome”. This term characterizes police stress as special. Some other researchers have referred to police stress as the “Police Paradox” (Cullen, Link, Travis and Lemming, 1983) because it combines both safe and unsafe aspects of the job that produce the symptoms. Many police stress reactions often result in the stage of full blown cynicism (Niederhoffer, 1969). “Police officers are constantly being faced with the unknown and unpredictable. They never know exactly what will be the outcome of a situation they are into. This makes policing a sensitive profession and such threats may include increased risk of infectious diseases, and serious or minor traumas, both physical and emotional” (Coman and Berry, 1991). Rhodin, (2002), “amounting up of these pressures has resulted in increasing stress caused by daily living a working situation may lead to various minor health problems leading further to changes in job performance and quality of life”.

1.2.7 Causes of Stress among Police Personnel

Mathur (1994) has rightly mentioned that police culture is the particular set of values and the outlook that police officers develop. Police stresses are parts of police culture and are usually divided into one of the four set of stresses:

(a) External (b) Internal (c) Task-related (d) Individual.

Mathur (1994) has rightly pointed out the sources of stress. They are related to personal factors like background of the individual and organizational factors. The initial attempts to define sources of stress in police work relied upon personal experience and observations. He has given illustration of Martin Symonds, a Patrol officer and psychiatric consultant in New York City Police who has divided the sources of stress into two broad categories:
Introduction

a) The nature of police work like negative response of the public, demands for good judgment and flexibility in stressful unpredictable situation, maintaining a constant state of ready alertness, functioning in public view etc.

b) The nature of the police organization which is a quasi-military structure and has the problems like law enforcement, promotions, hour of duty, etc. (Patterson and George, 2002).

Mathur (1995), has also identified some important chronic police stressors like neglected family life, job boredom, quantitative overload, noxious physical environment, poor communication channels, lack of support from senior officers, inadequate praise and rewards, procedural injustice, role ambiguity and role conflict. Neglected family life is one of the main causes of stress among Mumbai police force. It was a common guilt among the police staff at all levels that they are unable to spend qualitative and quantitative time with their spouse and children (Shipley, Peter and Joseph, 2002). The reasons are long hours of duty, absence of leaves, no planning of holidays, cancellation of leaves. This also generates stress among the family members. Some of them are under more stress when family members are unable to understand their problems, or they misunderstand them. The profession appears boring at times due to long periods of physical inactivity and monotonous work. This is more applicable to police constables having ‘bandobast’ duty on the road for VIP with long hours of waiting. Quantitative work overload is one of the reasons. It is a known fact that as compared to the developed countries, the policemen in India are burdened more than they are trained. Noxious physical environment, high level of air pollution and dangerous equipment are also responsible for the rise in the stress. Relationship with the superior, if not amicable can create further problems (Jackson and Christina Maslach, 1982). Policies concerning work assignments, procedures and personal conduct can also be listed as stressors among the police.

Stressful life events have been found to be associated with high incidence of certain psychological disturbances, e.g., depression, anxiety, post-traumatic stress disorder and certain other physiological problems like, hypertension, coronary heart-
Introduction

disease, chronic headache, migraine (Comer, 1992; Carson, Butcher and Mineka, 2000). Similar role is played by stress on the life of Police personnel. Numerous studies have well documented a close relationship between stress and health (Srivastava, 2002; Icovics and Park, 1998; Srivastava, 1997; Cooper, Liukkonen, Cartwright, 1996; Lazarus and Folkman, 1984; Selye, 1976).

1.3 Relationship between Stress and Health

Stress and illness has become an important focus of a relatively new field called ‘psychoneuroimmunology’ – the study of the relationships between psychological factors, especially stress, and the functioning of the endocrine system, the immune system, and the nervous system.

Various factors decide one’s health. Out of these factors, stress draws a crucial relationship with the health of an individual. Mathur (1993), in a survey of stress problems in Indian police personnel reported that “certain job related factors acted as specific stressors for the police such as their: work overload, work condition, lack of recognition, fear of severe injury or being killed on duty shooting someone in time of duty, inadequate equipment, anti-terrorist operations, confrontation with public, lack of job satisfaction and police hierarchy”. Occupational stress has been found to be associated with several psychological problems like tension, anxiety, psycho-somatic symptoms, indicators of personal functioning and other health outcomes (Billings and Moos, 1982; Ivancevich and Matteson, 1980; Kopelman, Greenhaus and Controlley, 1983). Saathoff and Buckman (1990) evaluated 26 state police officers and revealed that, “the most common primary diagnosis was adjustment disorders followed by substance abuse and personality disorders”. Misra (2005) reported that there has been a considerable rise in the suicide rates among Border Security Force jawans and incidents of shooting colleagues and sometimes even family members, in a fit of rage or frustration. Psychological signs involve heightened nervousness, feelings of sadness, anger or feeling depressed for time. Vena (1986), “ischemic heart diseases and acute myocardial infarction are very common among police officers with higher degrees of stress”. In a study by Basavanna (1996) on 2,354 police personnel from
Introduction

various ranks revealed, “the police hospitals shall regularly assess mental health of the personnel along with the physical health and the police personnel should be educated about the ways to cope up with job stress”.

1.3.1 Coping With Stress

Lazarus and Folkman (1984), “stress involves transactional relationships between individuals and their environment, which are appraised as taxing or exceeding their resources and endangering their well-being”. Thompson (1992) points out stress as, “not merely an object in the world, rather as a reaction of an organism to events in the world”.

“Stressors are objects and events and stress reactions are a kind of three responses both physiological and psychological like anger, fear, guilt, gloom that are exhibited when faced with a stressor”(Hamburg and Adams, 1967). Lazarus (1990) describes stress appraisal in three ways, “primary, secondary, and coping behaviors. Primary appraisal involves the individual’s perception of the stressor as harmful, threatening, or challenging. Secondary appraisal is the assessment of the person’s own coping resources available for dealing with the stressor”.

Lazarus (1993), “Coping behaviors are the specific cognitive and behavioral strategies that individuals use to deal with the stressor. It is the perception of demand and coping capacity which determines stress levels”. Folkman and Lazarus (1988), “The cognitive and behavioral efforts are constantly changing as functions of continuous appraisals and reappraisals of the person-environment relationship, which is also always changing”. Coping is flexible and goal-oriented. Lazarus (1993), “The function of problem-focused coping is to change the troubled person-environment relationship by acting on the environment or oneself. The function of emotion-focused coping is to change either the way the stressful relationship with the environment is attended to or the relational meaning of what is happening” (p. 238).

Stress-coping resources have been defined by Lazarus and Folkman (1984) as “the individual factors, traits, or assets that one uses in coping. When the resources lie
within the individual, they are considered internal; when they are outside, they are termed external. These resources are viewed mainly as mediators that can expand a person’s resistance to stress”.

“Coping is understood as stabilizing factor that may help individuals in maintaining psychological balance during periods of stress” (Lazarus and Folkman, 1984; Moose and Billings, 1982). Freedy and Hobfall (1994), pointed out that, “the persistence of stress and burnout across the time suggests the need for effective intervention programmes” (Wade, Cooley and Sivicki, 1986). Management of stress has been emphasized more by the investigators rather its removal (Cooper and Marshall, 1976). According to Kobasa (1979) an individual’s frame of reference, motives, competencies or tolerance to stress, play a chief role in deciding a person’s coping skills. “When a person finds himself competent enough to tackle a situation, a task oriented response is used. This response means that the situation is appraised by the individual objectively, a solution is worked out, appropriate strategy is undertaken, is followed by an action and evaluates the feedback” (Gazdella, Bernandette and Ginther, 1991; Jenkins, Susans and Calhoun, 1991; Parkes, 1990; Payne and Rajala, 1988). Pestonjee (1992), suggested that “stress leads to psychosomatic disorders. Because emotional states are mainly expressed in terms of bodily reactions, one way of balancing the negative effects of stress is performing regular exercises”. According to Bhole (1977), “breathing practices are designed to develop certain type of awareness within oneself”. According to Nagendra and Nagarathna (1988), “yoga acts as the key to combat stress”. Mathur (1999) concluded that “physical exercise can play a significant role both in combating stress and in increasing one’s ability to deal with stressful situation”. Swanson and Territo, (1983) suggested that physical fitness makes an officer feel more self-assured and happy with himself. Studies also show that expansion of awareness and self-esteem can cut down the impact of stress among police personnel (Swanson and Territo, 1983). Sarason, Johnson, Berberich and Siegal (1979) explored a cognitive behavioral approach for stress management of police officers. They concluded that “stress management may be most effective with law enforcing officers when the program is
Introduction

focused on the particular situations which are likely to be faced by trainees”. Somodevilla, Baker, Hill and Thomas, (1978) described ‘biofeedback training’ to have a positive impact on the ability to recognize and reduce stress in a ‘Stress Management Programme’ in Dallas police department. Pandya (1994) has carried out a stress management program on Mumbai police to help them in stress management using a holistic approach (Hindustan Times, 26 Nov. 1996.; Mathur, 1999). Sterling and Eyer(1988), “police personnel undergo various kinds of wear and tear of body in their extremely stressful working conditions”.

Stress-related disorders “can be checked if a person understands the role of stressors, how these stressors can harm him or her physically and emotionally, and how he or she can cope with stressors to reduce stress” (Pollak and Sigler, 1998). Moreover, the awareness of stress and its alleviation is the main focus of stress management (Apgar and Callahan, 1982).

Stress management programs can prove fruitful for police officers (Lazarus and Folkman, 1984; Wilson et al., 2001; Patterson, 2003) who are not able to control and alleviate stress.

1.4 Personality Traits of Hardiness and Optimism

Martin Seligman (1998), a Psychology Professor at the University of Pennsylvania and past President of the American Psychological Association led a group of psychologists in order to shift the emphasis from a disease model to a health model called “Positive Psychology”. It pushed the beginning of a new era in psychology. Rather than looking at how society’s negative aspects impact us, their aim is to discover the positive qualities that help people flourish, example : courage, optimism, hope, honesty, interpersonal skills, work ethic and perspective.

Two concepts, viz. hardiness and optimism have recently emerged within the area of psychological resiliency that helps one to overcome and deal with negative life experiences. In such role demanding stressful job conditions, the positive traits like
hardiness and optimism may play a positive role for police personnel to carry out their task effectively.

1.5 Hardiness

The concept of Hardiness was first identified by Kobasa (1982) as “a resistance factor”. Early findings revealed that “individuals, who experienced high levels of stress, but remained healthy had a different personality structure than individuals who experienced high levels of stress and became ill”. Hardiness, was further defined as “the use of ego resources necessary to appraise, interpret and respond to healthy stressors”. Researchers have begun to conceptualize hardiness as “a general health-promoting factor, which enables the individual to remain both psychologically and physically healthy despite confronted by stressful situations or experiences” (Maddi and Kobasa 1984; Maddi et al., 2006).

Maddi and Kobasa (1984) refined the previous view of hardiness as developed by Kobasa (1979) as, “Hardiness is a mediating factor in the stress-coping framework” (Williams, Wiebe and Smith, 1992). “Hardiness can change the stressful event into a positive reappraisal and reduce emotions such as anger and sadness” (Gentry and Kobasa, 1984). “High-hardy individuals engage in more adaptive coping strategies and less maladaptive coping than do low-hardy individuals” (Wiebe and McCallum, 1986; Blaney and Ganellen, 1990; Williams, et al., 1992).

“Hardiness appears to decrease the tendency to appraise events or circumstances as stressful” (Rhodewalt and Zone, 1989). According to Maddi and Hightower (1999), “Hardiness seems to motivate coping with stressful circumstances in a transformational rather than regressive manner”. Research has revealed a positive relationship between hardiness and conscientiousness in fostering positive health practices (Weibe and Mc Callum, 1986). “Hardiness has also been found to be positively related to the activity of the immune response” (Alfred and Smith, 1989). “The way in which hardiness cushions health and enhances performance is by its effect on the coping process” (Maddi and Hightower, 1999). Maddi and Kobasa
Introduction

(1984) hypothesized that “hardiness relies upon the kind of coping that can change events into some less stressful form”. People who are interested in performing activities, believe that they can exert influence and expect changes that result in personal growth. Such individuals feel more motivated to react to stressful events by enhancing their interaction with them. Transformed events are, therefore, less stressful and have a low ability to arouse the body's “fight or flight” reaction. This, in turn, decreases the overall likelihood of falling ill and breakdowns in performance. On the other hand, “individuals low on the dimension of hardiness are considered more likely to engage in regressive coping” (Maddi and Kobasa, 1984). “This implies lowered interaction with the stressful event by certain means like involving in disrupting alternative activities, living in a preoccupied and repetitive fashion on one's emotional reactions, and seeking reassurance in such a manner that personal change appears worthless”. People scoring low on hardiness dimension fall into ‘regressive coping’ which can add some short-term value to buffering the otherwise deteriorating effect of stressful events. This is because it can serve to take-away the person from the event both physically and psychologically. In cases of intense stress like sudden loss of a loved one, ‘regressive coping’ may serve as the best and that can be achieved in short time. But the moderating effect of ‘regressive coping’ involves only buffering in its effect as it has nothing to do with the termination of the budding event and its stressful components. “Therefore, there is risk with ‘regressive coping’ that it can reencounter the stressful event both physically (e.g., to avoid a difficult work situation one may go on a vacation but the problem still exists when one returns) and psychologically like painful memories of a lost loved one may still return even if expected despite various disturbances”. In contrast, ‘transformational coping’, “is more likely to terminate the stress of happenings and thereby achieve a detailed and prolonged moderating effect”. By dealing with the difficult work problem in reality, it can be resolved. And by a process of reliving and grief, peace of mind regarding the memories of the lost loved one can be achieved.

Hardiness has also a role to play in the health of an individual. Hardiness is described as a strong commitment to self, an attitude of rigorousness towards
Introduction

environment; a sense of meaningfulness, and an internal locus of control. Hardiness as a personality-construct was introduced by Kobasa (1979) as a means of explaining why some individuals remain healthy under high levels of stress while others fall-ill. According to the original conceptualization of Kobasa (1979), the hardy personality construct acts as a moderator of stress-illness relationship where hardiness is considered to be a source of resistance, a resource that can pacify the expected harmful outcome of stress (Antonovsky, 1987). Hardiness has been shown to neutralize the effects of stress by changing stress appraisals or generating more active coping. (Florian, Mikulincer and Taubman, 1995; Maddi and Hightower, 1999). King and Ellinwood (1988) conducted a study on the Vietnam war veterans where hardiness was found to be associated with lower likelihood of developing Post Traumatic Stress Disorder.

The Hardiness concept encourages a positive and optimistic view of coping with stress. Hardiness as a positive affect originates from Maddi’s fulfillment model (Maddi, 1976). This model theorizes that a person acquires capabilities, meanings, and values. Life’s stressful situations cause conflicts through challenging and inhibiting one’s capabilities, meanings and values. One must-be able to fulfill his capabilities, meanings, and values by continuing to carry them out and believe in them. High-hardy individuals are more likely than low-hardy individuals to interpret past experiences and stress as positive and controllable which also allows high hardy persons to evaluate current and future situations or stimulus as less threatening. Because stress is experienced as less threatening, avoidance and withdrawal from a stressful situation is unlikely. For this reason, high hardy people are less likely to use ineffective or regressive coping skills unlike individuals low in hardiness. Those high in hardiness actually use an optimistic transformational coping through viewing the situation as a chance to grow through the challenge.

Maddi’s fulfilment model along with initial personality tests used to measure hardiness involve control, commitment and challenge, which have-been derived from the existential theory and the fulfillment model. Hardiness has been defined in general
as the personality characteristic with the capability of enduring weariness and exertion from stress, pain, and suffering while strengthening from the process.

1.5.1 Control

This dimension is measured by the presence of mental power that an individual feels (Bigbee, 1985). “It refers to the notion that one can control or affect occurrences in one’s life, the efforts carried out can modify stressors so as to reduce them into a more manageable state” (Bigbee, 1985; Huang, 1995; Pollock, 1989; Tartasky, 1993; Wagnild and Young, 1991). The concept of control considers the level to which individuals perceive themselves as holding an internal locus of control.

1.5.2 Commitment

Antonovsky’s (1979) notion of meaningfulness, which is the second dimension of hardiness (i.e., commitment) is represented as “the ability to feel actively involved with others and a belief in the truth, value, and importance of one’s self and one’s experience” (Huang, 1995; Tartasky, 1993; Wagnild and Young, 1991). “Negative situations are finally seen as meaningful and interesting” (Maddi and Kobasa, 1984). “Individuals high on this dimension are committed to various aspects of their life including interpersonal relationships, family, and the self” (Low, 1996). “Commitment is reflected in one’s capacity to get involved, rather than feeling disconnected. As per existential point of view, this dimension represents a basic sense of one’s worth, purpose, and accountability, which acts as a shield against weakness while under adversity” (Bigbee, 1985; Pollock, 1989). Seligman (1995) suggested, “the difficulty with current Western society lies in its inability to find meaning in life”. Despite various philosophical arguments regarding the “meaning”, the true essence of the term becomes clear when individuals are able to link themselves to a larger entity and life has more “meaning”.

Introduction

27
1.5.3 Challenge

The third dimension, i.e., challenge, “reflects the notion that change is not a threat to personal security, rather it is an opportunity for personal development and growth” (Bigbee, 1985; Maddi and Kobasa, 1984; Pollock, 1989; Tartasky, 1993). “Challenge represents the individual’s positive attitude towards change and the belief that one can benefit from failure as well as success” (Brooks, 1994). “Fears surrounding potential mistakes and the feelings of embarrassment which are frequently a consequence of making them, prove to be a hindrance in overcoming challenges, thereby, personal growth” (Brooks, 1994). These fears lead to avoidance behavior which generates fear and prevents the individual from facing and overcoming the challenge.

“The combination of all these dispositions keeps a person healthy despite encounters with stressful life events” (Kobasa, 1979). Kobasa, Maddi and Kahn (1982) have demonstrated an interactive relationship between hardiness and effect of stressful life events in predicting illness symptoms. Research has shown that “some people are more resistant to stress and thus can better cope with it as compared to others and are called stress hardy personalities”. Kobasa and Puccetti (1983) found that “hardiness is associated with stressors and strains”.

“The individual’s cognitive appraisal of a stressful situation and his reservoir of coping strategies mediate the effects of hardiness on mental health” (Kobasa, 1982). Specifically, “hardiness alters two appraisal components - it reduces the appraisal of threat and increases one’s expectation that coping efforts will be successful” (Maddi et al., 2006; Genrty and Kobasa, 1984; Kobasa, 1982). Hardiness has also been shown to be linked with the individual’s use of active coping strategies for tackling stressful events.

1.6 Optimism

“The trait of optimism reflects an individual’s expectation of a positive outcome in most situations” (Scheier and Carver, 1985; Schneider and Leitenberg,
It has been argued that “optimism prepares the individual to define goals, make commitments, cope with adversity and pain and recover from trauma and stress”. Many studies have been conducted to examine the role of “Optimistic Bias” in adolescents and adults and it has been found that “there exists a strong relationship between an optimistic outlook and self-reported happiness” (Scheier and Carver, 1985; Schneider and Leitenberg, 1989). Michael Scheier and Charles Carver (1985) wrote an article (published in Health Psychology) in which they proposed a new definition of optimism, “optimism is a stable tendency to believe that good rather than bad things will happen”. Scheier and Carver (1985) reported that, “when a goal is of sufficient value, the individual would produce an expectancy about achieving that goal”.

In their definition of optimism, Scheier and Carver (1985) purposefully do not emphasize the role of personal efficacy. “The generalized outcome expectancies may involve perceptions about being able to move toward desirable goals or to move away from undesirable goals”. Optimism may be considered as a faith to which achievement is the outcome. Nothing is possible without hope or confidence. An optimist is someone who sees “silver lining in every cloud and views the world through rose-tinted spectacles “(Restonon, 2005). Possessing optimistic attitude has many benefits. “When coping with stressors, optimists appear to take a problem-solving approach and are more planful than pessimists” (Scheier and Carver, 1986). Furthermore, “optimists tend to use the approach-oriented coping strategies of positive reframing and seeing the best in situations, whereas pessimists are more avoidant and use denial tactics”. Optimists appraise daily stresses in terms of potential growth and tension reduction more than their pessimistic counterparts do. Also, “when faced with truly uncontrollable circumstances optimists tend to accept their plights, whereas pessimists actively deny their problems and thereby tend to make them worse” (Scheier and Carver, 1998, 2001). In other words, “an optimist knows when to give up and when to keep plugging, whereas the pessimist still pursues a goal when it is not a smart thing to do”. Interest in the topic of optimism has greatly
increased with the beginning of the positive psychology movement by Martin Seligman (1998).

Lionel Tiger (1979) presented a useful definition of optimism as “a mood or attitude associated with an expectation about the social or material future—one which the evaluator regards as socially desirable, to his advantage, or for his pleasure”. An important implication of the definition, proposed by Tiger, is that “objective or single optimism can’t occur, because optimism depends on what the individual regards as desirable”.

As per contemporary approaches optimism is treated as a cognitive characteristic which has—“a goal, an expectation, or a causal attribution. Optimism is not just cognition, but there entails an emotional flavor that pervades optimism”. It implies the fact that “optimism is both motivated and motivating. Indeed, people do need to feel optimistic about certain matters”. However, optimism and pessimism can have defensive as well as ego-enhancing aspects.

1.6.1 Optimism: Innate Tendency

Optimism has taken two forms: “Firstly, it is considered to be an inherent part of human nature, to be either cherished or disliked”. In early approaches to optimism, it was considered to be negative. Sophocles and Nietzsche (2006) argued, “optimism prolongs human suffering and it is better to face the hard facts of reality”. This negative view of a positive characteristic is the focus of Freud's writings on the subject.

Freud (1928) wrote “The Future of an Illusion”, where he described that “optimism was widespread but illusory. It is optimism that makes civilization possible, and that too when institutionalized as religious beliefs about an afterlife”. However, being optimistic leads to render a cost, which is the “denial of our instinctual nature and hence the denial of reality”. Religious optimism makes people happy that “these sacrifices are necessary for the growth of the civilization and is at the core of what was termed as the ‘universal obsession neurosis’ of humanity”.

30
Freud proposed that “optimism is part of human nature in the form of the conflict between instincts and socialization. He mentioned that “some individuals did not need the illusion of optimism”. According to Freud, (1928) “a rational prohibition against murder is not compelling to the masses. It is more persuasive to assert that the prohibition comes directly from God”.

Tiger (1979) in his book – ‘Optimism: The Biology of Hope’ made the strongest statement that “optimism is in the biology of our species and suggested that it is one of our most defining and adaptive characteristics. He further proposed that optimism is a significant part of human nature, which emerged in the course of evolution, and developing along with our cognitive abilities”.

Tiger (1979) also suggested that “optimism is the force that drives human evolution. Because optimism involves thinking about the future, it first emerged when people started to think of the future. Once people began thinking about the future, they could anticipate worst consequences, including their own mortality. Something was required to develop to neutralize the fear and paralysis born due to such thoughts, and it was optimism”. According to this view, “optimism is inborn in people, and not an outcome of some other psychological trait”. Tiger formulated that “optimism is easy to think, learn, and is pleasing and is described by modern evolutionary psychologists as an evolved psychological mechanism” (Buss, 1991).

1.6.2 Optimism As An Individual Specific Trait

Psychologists interested in individual differences began to consider optimism as a trait that people possess to varying degrees. Human nature provides a standard optimism baseline, on which individuals stand on the scale of more versus less. Tiger, (1979), “In dealing with natural systems the shortest analytical distance between two points is a normal curve and it is the experiences of an individual that decide the degree to which one is optimistic or pessimistic”.

“The traditional stimulus–response (S–R) approaches to learning and their substitution with cognitive trends emphasizing expectancies also played an important
Introduction

role in leading psychology's interest in optimism as an individual difference” (Peterson, Maier and Seligman, 1993.) According to S–R approaches, learning means the acquisition of specific motor responses in particular situations. According to this view, “learning entails the forming of associations between stimuli and responses, and the more closely these are linked to each other in experience (contiguity), the more are the chances of learning to occur” (Seligman et al., 1993). According to behaviorism, “learning was thought to have no cognitive representation”.

Types of Optimism

There are two styles of Optimism: Optimistic Explanatory Style and Dispositional Optimism.

Explanatory style is explained as, “the manner in which people normally explain their life events. It originated from attribution theory and Seligman’s work of learned helplessness”. Seligman proposed that “our motivation the can be potentially drained due to the way in which we choose to explain events in our lives, reduce our persistence and increase vulnerability to depression. This style has three dimensions, internal vs. external, stable vs. unstable and global vs. specific”. The explanation for a good event in Explanatory Optimistic Style would be internal. “It relates to one’s characteristics and stability. However, the opposite would be true for an optimistic explanation of a negative event”.

On the contrary, “dispositional optimism, is a generalized expectancy for favorable outcomes” (Scheier and Carver, 1987). Dispositional optimism has been found to buffer the effects of stressors in numerous studies. Patients with Dispositional Optimism who had undergone coronary artery bypass surgery were found to show a significantly faster rate of recovery than pessimists.

“Volumes of robust research have added value to the field of Psychology in general. Above hundred studies have been carried out to measure the impact of optimism on people’s lives. Optimism has been shown to add to physical and mental
health, longevity, performance excellence, creativity and to success in attaining goals and dreams” (Srivastava, 1997).

1.6.3 Optimism and Health

“Optimism has found to be linked with persistence with health related matters and positive health outcomes” (Chamberlain; Scheier and Carver, 1985, 1987). Also optimism has been shown to be positively associated with “psychological characteristics linked with healthy behavior and good health, including internal locus of control and high self-esteem” (Lightsey, 1996). Smith, Rhodewalt and Poulton, (1989), “people with optimistic outlook have been seen to report better physical health, but it has also been suggested that optimists report better physical health because of their better psychological adjustment which can be seen as a reporting bias”. A number of studies have demonstrated positive effects of optimism with regard to cardiovascular system, for e.g., “optimism has been found to lower ambulatory blood pressure” (Raikkohen, Mathews, Flory, Owens and Gump, 1999). In a laboratory study, “optimists have been found to be more likely to engage in difficult tasks as compared to pessimists” (Sieber, Rodin, Larson, Cumings, Levy and Whiteside, 1992). Aspinwall and Taylor (1992) supported the hypothesis that, “the more optimistic an individual is, the lower his perceived stress levels will be”. Segerstrom, Taylor, Kemeny and Fahey (1998) revealed that “dispositional optimism and perceived stress are negatively correlated”.

Even though it is a widely accepted fact that “stress is a factor in poor physical and mental health”, this area has not been researched much and also there have not been much researches regarding the factors that can moderate this relationship. Mathur (1995) also considered the area at present to be largely neglected.

With the advent of modern society becoming a host of criminal activities, the task of police personnel is becoming even the more risky and challenging, where they have to meet the unexpected at every step.