REVIEW OF LITERATURE

Positive life-style changes can prevent the individual from many chronic and common diseases. People are encouraged to adopt health enhancing behaviors as a part of their daily lives, and to make strong efforts to prevent illness. Our health is affected by various psychological and environmental variables. The aim of the present investigation was to study Health Protective Behaviors in relation to psychosocial variables viz. Personality dimensions, Positive and Negative Mental States, Mental health, Psychological Well-being, Perceived Social Support, Stress and Coping, Self-Esteem, Self-Efficacy and Health Habits, Perceived Family Environment and Perceived Parental Health Orientation.

CONCEPTUAL FRAMEWORK

PERSONALITY

Personality is considered as a unique pattern of traits, which characterize the individual. Personality is not a fixed state, but a dynamic totality, which is continuously changing due to interaction with the environment.

The term ‘personality’ is much older than the term ‘psychology’ itself (Mohan, 1985). Personality has been recognized as a very important determinant of human behavior. This popular concept of personality reflects its origin in the classical Latin word ‘persona’ a mask worn by Roman actors.

Allport (1937) defined personality as “the dynamic organization within the individual of those psychophysical systems that determine his unique adjustments to his environment.

Eysenck and his co-workers gave a dimensional approach to personality at descriptive and causative levels, and ushered a new era in the study of personality.
The present study explored the etiological role of personality dimensions viz., Eysenckian Personality dimensions, Hardiness, Health Locus of control AND State-Trait Anxiety in Health Protective Behavior.

EYSENCK’S THEORY OF PERSONALITY

Eysenck’s theory of personality is one of the formidable attempts in presenting a complete and explanatory theory. Eysenck (1968) defined personality as, “a more or less stable and enduring organization of a person’s character and temperament, intellect and physique which determines his adjustment to the environment”. Character denotes a person’s more or less stable and enduring system of conative behavior (will); temperament, his more or less stable and enduring system of affective behavior (emotion); intellect, his more or less stable end enduring system of cognitive behavior (intelligence); physique, his more or less stable and enduring system of bodily configuration and neuroendocrine endowment. (Eysenck, 1970). Eysenck’s definition of personality revolves around four behavior patterns: the cognitive, the conative, the affective, and the somatic. Thus, personality, according to Eysenck, is the sum total of actual or potential behavior patterns of organism as determined by heredity and environment.

Eysenck developed and presented an exhaustive personality theory on the basis of intensive research over the years (1947, 1960, 1963, 1967, 1971, 1981). He posited four independent major dimensions of personality, viz., Extraversion/introversion (E/I), Neuroticism (N), Psychoticism (P) and Intelligence (cognitive ability) (Mohan et al., 1987).

The Dimensional Approach

The three basic dimensions of personality given by Eysenck (1985) are Extraversion / Introversion, Neuroticism, and Psychoticism. Later on another dimension called lie (social desirability) scale was added in the personality questionnaire of Eysenck.
Extraversion / Introversion

On the descriptive side, Eysenck (1967) deducted the concept of Extraversion / Introversion (E / I) from the nosological categories based on Jung's (1923) views and supported by Hildebrand's study (1958) and on the causative side, from Pavlov's (1941) excitation inhibition balance in the Central Nervous System (CNS), Hull's (1943) reactive inhibition and Gray's (1964) level of arousal.

Eysenck and Eysenck (1968) proposed that extraversion refers to the outgoing, uninhibited, impulsive, and social inclinations of person. The typical extravert is sociable, likes parties, has many friends, needs to have people to talk to, and does not like reading or studying himself. He craves for excitement, takes chances, often sticks his neck out, acts on the spur of the moment, and is generally an impulsive individual. He is fond of practical jokes, always has a ready answer, and generally likes to laugh and be merry. He prefers to keep moving and doing things, tends to be aggressive and loses his temper quickly; although his feelings are not kept under tight control. He is not always a reliable person.

The typical introvert is a quiet, retiring sort of person, introspective, fond of books rather than people; he is reserved and distant except to intimate friends. He tends to plan ahead, looks before he leaps. He does not like excitement, takes matters of everyday life with proper seriousness, and likes the well-ordered mode of life. He keeps his feelings under control, seldom behaves in an aggressive manner, and does not lose his temper easily. He is reliable, somewhat pessimistic and places great value on ethical standards (Eysenck, 1965).

Neuroticism

The second major personality dimension deducted by Eysenck (1947) was neuroticism/stability. Neuroticism refers to a general, emotional over responsiveness, emotional liability, and liability to neurotic breakdown under stress. Neuroticism is closely related to the inhibited
degree of liability of autonomic nervous system (Eysenck, 1964, 1967). According to Eysenck and Eysenck (1968), neuroticism as contrasted to emotional stability is very much similar to anxiety.

A high scoring individual on neuroticism tends to be anxious, worrying, over responsive and depressed. He reacts too strongly to all sorts of stimuli and finds it difficult to get back on an even heel after each emotionally arousing experience (Ibrahim, 1979). His strong emotional reactions interfere with his proper adjustment, making him react in irrational ways (Eysenck and Eysenck, 1975). Such individuals frequently complain of vague somatic upsets of minor kind, such as headaches, digestive troubles, insomnia, backaches etc. and also report many worries, display anxieties and other disagreeable emotional feelings. Such individuals are predisposed to develop neurotic disorder under stress, but such predispositions should not be confused with actual neurotic breakdown. A person may have high scores on neuroticism, yet functioning adequately in work, sex, family, and social sphere (Eysenck and Eysenck, 1968).

Psychoticism

Eysenck and Eysenck (1975) and Howarth (1986) reported that a high scorer on Psychoticism possesses the following traits: Impulsiveness, lack of cooperation, oral pessimism, rigidity, lower super ego controls, low social sensitivity, low persistence, lack of anxiety, egocentric, impersonal, lack of feelings of inferiority, unempathic, creative, aggressive, cold, antisocial and tough minded.

A high scorer on Psychoticism is described as being solitary, crude, inhuman, insensitive, hostile, and aggressive.

Lie-Scale (Social Desirability)

The lie (social desirability) scale (L) was first incorporated in the Eysenck Personality Inventory (EPI) to measure a tendency on the part of the subjects to fake good responses. A series of factorial and experimental
studies have been carried out to investigate the nature of this scale in some detail (Eysenck, 1971). This scale possesses a considerable degree of factorial unity.

It is being considered as a tendency to respond in a socially desirable way; it is variously described as a desire to conform to social norms (Edwards, 1954); nice personality (Skinner et al., 1970); ideal self and ideal responses (Choudhary, 1972).

Verma (1977) on the basis of exhaustive review of literature on the Lie (social desirability) scale was of the opinion that this is a powerful independent factor of personality, which needs to be studied in its own right.

HARDINESS

It is assumed that hardiness as a trait has close link with other personality traits. The personality dimension of hardiness has received its due by the researchers acknowledging its role as a protective factor against illness.

According to Kobasa (1979), "Hardiness is a personality dimension that is believed to confer resistance against the effects of psychological stress. Hardiness is a composite consisting of internal locus of control, commitment and challenge". Kobasa et al., (1982) have also defined each component differently: "Commitment is a tendency to involve one self in whatever one is doing or encounters. Challenge is a belief that changes rather than stability is normal in life and that the anticipation of change is interesting and an incentive to growth rather than threat to security. Control is a tendency to feel and act if one is influential in the face of the varied contingencies of life".

Kobasa (1979, 1982) reported that a hardy individual possesses a strong sense of control, commitment and challenge, which act together to help buffer the debilitating effects of life stresses, such as physical illness.
STATE-TRAIT ANXIETY

The Dictionary of Psychology and Psychiatry defines anxiety as a pervasive feeling of dread, apprehension, and impending disaster. Anxiety should be distinguished from fear. Fear is response to a clear and present danger while anxiety is a response to an undefined and unknown threat which in cases stems from unconscious conflicts, feelings of insecurity or forbidden impulses within ourselves. In both, the body mobilizes itself to meet the threats and muscles become tense, breathing is faster and heart beats more rapidly.

Rachman (1998) defined anxiety as “a pervasive and significant negative affect that is a central feature of many psychological problems”.

In short, anxiety as a process refers to a sequence of cognitive, affective, physiological, and behavioral events. A-State is characterized by feelings of tension, apprehension, worry, and autonomic arousal occurring in response to perceptions of either threats to personal adequacy or objective physical danger. A-Trait specifically refers to the tendency of individuals to response with A-State elevations to situations, which are perceived as potentially threatening to self-esteem (Mohan, 2000a).

At various times, anxiety has been conceptualized as a response, a stimulus a trait, a motive and a drive (Spielberger, 1972). Anxiety is defined as a complex state that includes cognitive, emotional, behavioral, and bodily reactions. Worry refers to the cognitive aspect of anxiety whereas Anxiety refers to its awareness (Spielberger, 1966).

Spielberger (1971) has described personality states and traits as kinetic energy refer to palpable empirical reactions or processes taking place here and now at a given level of intensity. Personality traits like potential energy represent latent dispositions to respond with certain types of reaction if triggered by appropriate stimuli. State Anxiety (A state) is a transitory emotional state or condition of human organism that varies in intensity and fluctuates over time. This condition is characterized by
subjective consciously perceived feelings of tension, apprehension and activation of ANS (Spielberger, 1966).

Spielberger (1966) proposed that trait anxiety reflects anxiety proneness, that is stable i.e. there were individual differences in the tendency to respond with increased state anxiety to various levels of stress.

A considerable body of research has been developed in the area of State-Trait Anxiety (Spielberger, 1966, 1972). The essence of this conceptualization of Anxiety is that there is a distinction between anxiety as transitory emotional state which varies in intensity across time and situation (A-State) and the relatively stable personality dimension reflecting individual differences in anxiety proneness (A-Trait).

A-State is characterized by feelings of tensions, apprehensions, worry and autonomic arousal occurring in response to perceptions of either threats to personal adequacy or objective physical danger. A-Trait specifically refers to the tendency of individuals to respond with elevations to situations which are perceived as potentially threatening to self-esteem.

Webster (1981) defined anxiety as a “painful uneasiness of mind over an impending or anticipated ill”.

American Psychiatry Association (1994) considers anxiety as “a danger signal felt and perceived by the conscious portion of the personality. It is produced by a threat from within the personality – with or without stimulation from external situations”.

HEALTH LOCUS OF CONTROL

Rotter (1954) conceptualized locus of control orientation as an individual’s generalized expectancy regarding the degree to which one’s own behavior is a controlling factor in securing reinforcements in general. It has been observed that individuals differ in their perception of Locus of Control.
Locus of control means location of control (Adler, 1995). As a personality construct, it refers to where one believes the point of control for one’s life’s circumstances and outcomes is located. Locus of control is a critical determinant of our reactivity to stressful situations.

Locus of control is generally referred to as either internal or external. Persons with an internal locus of control tend to believe that control over their life is located within themselves. They may believe that the amount of money they make, the kind of job they have, the kind of grades they get in school and their physical health are all factors within the realm of their control (Crandall et al., 1960 and Lefcourt, 1966). Internally controlled persons tend to believe that if they are dissatisfied with any aspect of their life, they can change it through their own efforts (Abramowitz, 1973). Internally controlled persons also tend to feel responsible for the way their life is going at the moment and feel a sense of personal responsibility for both the negative and positive events that occur in their life (Cromwell, 1967). People who score more towards the “Internal” direction seem to more achievement-oriented and less conforming and complaint, more intelligent, to support political positions that stress individual responsibility and to take more reasonable risks (Strickland, 1977). People who are more internally oriented handle threatening situations effectively.

In contrast, externally controlled individuals tend to believe that control over their life is located outside themselves. External persons may believe that luck or chance, or other people, or governmental forces play a greater role in determining what happens to them than their own actions do (Levenson, 1975). Externally controlled persons tend to feel helpless in directing their life. External persons may believe that the job they have is simply a matter of good or bad luck. The amount of money they make has nothing to with how hard they work. Getting good breaks in life may simply be a matter of being in the right place at the right time – it does not have any relationship to personal efforts (Broedling, 1975 and
Lefcourt, 1966). Externally oriented people may be sensitive to factors in a situation that might interfere or block their efforts. Such people may be first to perceive obstacle and may be better able to cope effectively with them (Phares, 1976). Thinking of people as being totally internally or totally externally controlled is inappropriate. In reality, locus of control is a continuum. In some situations, one believes one has some control; in others, one believes one is being manipulated.

Rotter (1966) postulated that consistent individual differences exist with response to person’s belief in the way his/her behavior will affect the control of events. These beliefs originated from Rotter's Social Leaving Theory. An individual who perceives his or her illness as consequence of one’s own behavior is said to have Internal Locus of control. Such person is likely to recover soon but an external person tends to perceive his behavior as determined by external events beyond its control such as fate, powerful others etc. This is negatively expectancy and he/she is unlikely to progress.

POSITIVE AND NEGATIVE MENTAL STATES

Emotions can affect health through many pathways; these influences may occur indirectly, through health behaviors or compliance with medical regimens, and directly through alterations in the functioning of central nervous system, immune, endocrine, and cardiovascular systems.

The health-enhancing and preserving effects of positive mental states have been proven sufficiently. The present investigation has focused on some dimensions of positive and negative mental states as related with Health Protective Behavior viz. Satisfaction with life, Optimism, Happiness and Irritability.
OPTIMISM

The Comprehensive Dictionary of Psychology defined Optimism as “a highly general attitude or personality trait that sees good in most objects and events and expects outcomes to be favorable”.

Optimism is an important psychological construct. Scheier and Carver (1985) regard dispositional optimism as a stable coping resource. The personality disposition of Optimism facilitates one in goal-directed behaviors, helps in coping with stress in a better fashion (Scheier and Carver, 1985) and leads to health enhancing states. It thus confers beneficial effects on physical well-being. Scheier and Carver (1985) opined that optimism is a general feeling and inclination to hopefulness and confidence. It is a disposition to take a bright and hopeful view of things. It is one extreme of continuum with the other extreme being pessimism.

HAPPINESS

Wilson (1967) opined, that “happiness is a lasting, complete, and justified satisfaction with life”.

Davitz (1970) reported that happiness is associated with ‘pleasant mood-states’.

Beusekom (1973) opined that “happiness is the satisfaction experienced in relation with one’s (social) environment”. According to Chekola (1974) said that happiness is “…realizing of a lifespan and the absence of seriously felt dissatisfaction and an attitude of being displeased with or disliking one’s life”.

Schulz (1979) said, “Happiness is integration (of identity), fulfillment (of needs), and extension (contrary to alienation). Veenhonen (1984) defined happiness as “the degree to which an individual judges the overall quality of his life-as-a-whole favorably”.

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IRRITABILITY

The quality of being provoked and getting angry or fretful in the process of interaction with others has been termed irritability.

The Longman Dictionary of Psychology and Psychiatry (1984) defined irritability as “a state of excessive, easily provoked anger, annoyance or impatience as also the capacity of living matter and particularly nervous tissue to respond to stimulation”.

People high on this trait lose their temper easily, though they also happen to get over it quickly. They are impatient, rude and get irritated at minor and unimportant things. They can be termed as being grouchy most of the time and are exceptionally annoyed if they think they are not being treated rightly by others (Buss and Durkee, 1957).

Irritability represents a readiness to explode with negative affect at the slightest provocation. It includes quick temper, grouchiness, exasperation and rudeness (Buss, 1961). Assault, verbal hostility, indirect hostility, and negativism are all forms of aggression, while resentment and suspicion represent hostility.

So, Irritability may be described as anger which may remain latent or become manifest in angry aggression.

STRESS AND COPING

There is overwhelming evidence that stress is a particularly important mediator of health-behavior relationships because it is a common and inevitable aspect of life and its broad effects can influence a range of bodily systems and behaviors. Stress appears to involve more or less simultaneous activation of psychological and biological system hence plays a crucial role in the etiology of chronic disorders (Cohen and Williamson, 1988).

Cofer and Appley (1964) defined stress as the state of an organism in which his/her well-being or integrity was perceived to be endangered; he/she feels that all energy must be diverted for its protection.
According to Scott and Howard (1970), “If the individual is unable to mobilize personal or social resources to cope with the situation and restore homeostasis, his or her energy will be bound up in dealing with this perceived disturbance. This preoccupation defines a stressful condition”.

Lazarus (1971) contended that stress refers to a very broad class of problems differentiated from other areas because it deals with (a) any demand which taxes the system and (b) response of that system. Such reactions would depend on how the person interprets or appraises consciously or unconsciously the significance of harmful, threatening or challenging events.

Selye (1976) opined that stress is the nonspecific response of the body to any demand made upon it whether that demand produces pleasure or pain.

**Stressors are of two types viz. Daily Hassles and Life Event Stress**

a) Daily Hassles

b) Life Event Stress

**DAILY HASSLES**

Minor events or daily hassles are those stressors which a person experiences in the process of his everyday life situation (Hahn, 1999). They are different from major life events and tend to have different negative behavioral outcomes. Daily hassles were defined as the irritating, frustrating, distressing demands that to some degree characterize everyday transactions with the environment. Hassles are irritants – things that annoy or bother us, they can make one upset or angry (Kanner et al., 1981). Some hassles occur on a fairly regular basis and others are relatively rare. Hassles are the minor negative events while uplifts are minor positive events (Stone et al., 1987). Hassles are related to the health of an individual. The influence of stress may be more apparent if it is linked in time with the health outcome investigated and
therefore the best measure for illness research is likely to be minor events (Swartz, 1991).

**LIFE EVENT STRESS**

Dohrenwend and Dohrenwend (1980) have extracted the most important objective stress-inducing properties of a life event:

(i) the event's negative valence;
(ii) it is fatefulness-(control over occurrence);
(iii) the extent to which the event is life threatening;
(iv) The magnitude of change in usual activities that is likely to be brought about for an average person experiencing the events;
(v) whether the change is likely to be physically exhausting.

Life stress process consists of three main structural components (Dohrenwend & Dohrenwend, 1980). The first is the stimulus components of life events, ranging from extreme situations such as man-made or natural disasters to more usual events such as marriage, the birth of a child, divorce and job loss.

The second component is ongoing social situation that includes individual's occupational circumstances, domestic arrangements and social network, which existed before the occurrence of life events.

The third component consists of the personal characteristics or disposition of the individual exposed to the life event. It included the individual's genetic vulnerabilities, past experiences with episodes of physical illnesses and personality characteristics.

**COPING**

When stress crosses an optimum level, it loses its positive aspect and become distress. A given situation becomes stressful only when one lacks the resources to deal with it. Increased levels of stress threaten an individual's well-being and produce automatic, persistent attempts to relieve the tension. Stress forces a person, to do something in dealing with stress and the consequences of stress. Such a stress does not maximize
performance but decreases effectiveness. Where effective coping helps to maintain equilibrium, ineffective coping leads to maladjustment and disease. Several coping measures and models have been proposed and there are now a number of ways to conceptualize and categorize the ways people cope with threatening or demanding situations (Carver et al., 1989 and Endler and Parker, 1990).

Coping is described as either a subcategory of defense (Cohen and Lazarus, 1979) or a reaction that appears in adversities (White, 1974). Its meanings are concretized as particular strategies appropriate for the special situation. Coping mechanisms include individual's own attempt to change their appraisal of stressors as less threatening and include individual's attempts to regulate emotions of distress. According to White (1974) coping is a process involving efforts towards solution of problems. Coping would occur when an individual confronts a fairly drastic change or problem that defies familiar ways of behaving, requires the production of new behavior and very likely gives rise to uncomfortable efforts like anxiety, despair, guilt, shame or grief the relief of which forms part of the needed adaptation.

Lazarus and Folkman (1984) describe coping to operate in two different ways –

**Coping Strategies are:**

1) Problem focused i.e. by changing the person environment relationship to decrease stress.
2) Emotion focused i.e. by changing only the way we intend to or interpret the stress.

Coping behaviors are attempts by individuals to deal with stressful transactions. The notion of coping can be applied not only to methods of handling specific episodes but also to styles or patterns of cognitions and actions which individuals characteristically adopt to avoid or reduce stress (Robinson and Inkson, 1994).
Some researches usefully distinguish between problem-focused (directly addressed the stress-creating matter) and emotion-focused (adjusting or responding to the matter through an emotional change) coping styles Billings and Moos (1984), while others add a third style – appraised-focused coping based on cognitive analysis, redefinition and avoidance.

MENTAL HEALTH, PSYCHOLOGICAL WELL-BEING AND PERCEIVED SOCIAL SUPPORT

MENTAL HEALTH

Longman’s Dictionary of Psychology and Psychiatry (1984) defines mental health as a state of mind characterized by emotional well-being, relative freedom from anxiety and disabling symptoms and a capacity to establish constructive relationship and cope with ordinary demands and stresses of life. From this perspective, the primary purpose of promoting wellness is to reach high levels of physical, psychological, and emotional fitness and to increase resistance to both minor illness and life-threatening disease. By and large, good health enables the individual to lead productive life, physically, socially and financially. Health and pursuit of well being is the basic right of every individual and should be the motive of everyone.

Bhatia (1982) defined mental health as the quality to balance feelings, desires, ambitions, and ideals in one’s daily living. It means the ability to face and accept the realities of life.

Mental Health refers to the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community and society (Gove and Zeiss, 1987).
Mental health has been mentioned as the ability of the person to balance one's desires and 'aspirations', to cope with life stresses and to make psychosocial adjustments (Veenhonen, 1991b).

**PSYCHOLOGICAL WELL BEING**

Cantril (1965) emphasized life satisfaction and happiness as a component of life – quality. Happiness, in turn, according to Bradburn (1969) results from a balance between positive affect and negative affect and as a preponderance of positive affect and negative affect. Life satisfaction, according to Campbell et al., (1976) reflects individuals' distance from their aspirations.

Theories of well-being span two basic approaches: cognitive-oriented and affect-oriented. Cognitive-oriented theories generally maintain that deficits in meeting one's needs lead to ill-being and that positive discrepancies between perceived reality and personal aspirations lead to well-being (Duncan, 1975; Brickman et al., 1978; Wills, 1981; Michalos, 1985 and Heady and Wearing, 1989). Affect-oriented theories of well-being suggest that self-satisfaction is enhanced by short term positive experiences or reducing aversive states. From this perspective, well-being reflects the feelings people experience during their everyday lives (Diener and Larson, 1993).

Diener (1984) suggested three categories for grouping the meanings of well-being. The first involved the assessment of the qualities of individuals (for instance, virtuousness, success) by others, and hence cannot be thought as a subjective state. The second encompasses the individual's assessment of satisfaction with life. Finally, the third meaning focuses on the amount of positive and negative affect experienced by an individual. Well-being is, therefore, much more than just an absence of disease.
PERCEIVED SOCIAL SUPPORT

Cobb (1976) has defined social support more specifically as information that leads individuals to believe that they are cared for as loved, are esteemed and valued, and belong to a network of communication and mutual obligation. These three areas of information include ‘Esteem support, Emotional support and Community support’.

Social Support refers to the help and support people receive from family, friends, and society in times of adversities and need. Social Support is a mediating factor that acts as a buffer against the adverse effects of life stress. Social support protects the individual against disease and aids in recovery by providing a buffer against stress.

Social Support encompasses an individual’s positive and negative interactions with member’s of society, especially with friends and relatives. Social Support creates an atmosphere where the individual feels cared for and valued. Two essential constructs of social support are Perceived Social Support and Received Social Support which is weakly inter-related (Sarason et al., 1987 and 1992).

Schaefer et al., (1981) also identified three dimensions of social support namely Emotional support, which involves intimacy and has to do with receiving reassurance; Tangible support or the provision of direct aid and services; and Informational support, which includes advice concerning solutions to one’s problems and feedback about one’s behavior.

SELF-ESTEEM, SELF-EFFICACY AND HEALTH HABITS

SELF-ESTEEM

According to Cohen (1959), “Self Esteem concerns the amount of value an individual attributes to various facets of his person. It may be defined as the degree of correspondence between as individual’s ideal and actual concept of himself”.

According to Coopersmith (1968), “Self esteem refers to individual’s personal judgment of his own worth”.

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According to Crandell (1973), “People’s self-esteem has to do with their self-perceived competence and self-image”.

Self-esteem can also be interpreted as the degree to which one possesses self respect and self acceptance. Self-esteem generally connects the positive and negative value one places on one’s own attributes. (Greenberg et al., 1999).

Self-esteem refers to one’s feelings about one’s inside qualities. This includes his feeling of worth as human being, sense of purpose in life and how lovable he thinks he is. It is quite usual to find that Self-esteem is confused with Self-image. Self-image refers to one’s thoughts about his outside appearance, what he thinks others see. This includes his looks, talents, popularity or accomplishments (Johnston, 2001).

Self-esteem, an affective aspect of the self, is defined as “the degree to which an individual has a favorable or unfavorable opinion of himself and finds himself worthy or unworthy” (Brooks et al., 2002). Higher self-esteem has been related to positive health behavior.

GENERALISED SELF-EFFICACY

The belief that one succeeds at something that one wants to do is known as self-efficacy Bandura (1977). One decides whether or not to carry out a healthy behavior by deciding whether it will achieve the desired effect and then whether one is capable of doing it. One may know that exercise will help one to be fit but we might not feel capable of doing it.

Thus, Self-efficacy is defined as the ‘belief in one’s capabilities to organize and execute the courses of action required to produce given attainments” (Bandura, 1997).

HEALTH HABITS

Health Habits include behaviors like eating habits, exercise, physical fitness and avoidance of alcohol and drugs use.
PERCEIVED FAMILY ENVIRONMENT AND PERCEIVED PARENTAL HEALTH ORIENTATION

One spends one third of one’s life at home, with family members. Family does not only provide emotional nourishment but it also provides the environment of security. Family environment and family member’s adaptation mutually influence each other. More specifically each adult family member’s personal characteristics, coping skills and well-being can affect the quality of family relationships, the family’s emphasis on personal growth goals, and the family’s focus on system maintenance. That is why when an adult in a family has a behavioral or emotional disorder the family environment is likely to be affected (Murphy, 1982). Other factors that influence the family climate are children’s personal characteristics, coping skills, well-being, acute life crises and on going stressors and resources from settings outside the family such as school and work. Moreover life crises such as child’s serious physical illness can also alter the family member’s coping skills and personal characteristics (Murphy, 1982). Thus, a cohesive family can affect adult’s coping skills and functioning. It can also influence children’s cognitive and emotional development, self-confidence and well-being. The family environment can influence both dysfunctional and other family member’s well-being. For example, a cohesive, well-organized family can foster an alcoholic father’s remission and his children’s adaptation.

Differences in the family’s communication patterns provide valuable information about the production and handling of meaning inside the family. This information provides useful clues about how children can develop (Kazdin, 2000). Family directly influences the development of personality by holding, communication and differential but just reinforcement. It also influences indirectly where family members are the persons with whom the child identifies, models after, in behavioristic
speech. The mirror image of self is gradually developed by viewing oneself through the eyes of family members (Kazdin, 2000).

Parents are important agents of socialization training in children (Maccoby and Jacklin, 1983), parent-child interactions are likely to contribute to the development of children’s relational schemas and scripts. Bronfenbrenner (1961) suggested that the origins of social cognitive heuristics involved in social information processing are likely to include past social interactions with parents. Bronfenbrenner (1961) and Francis, (1981) opined that negative family environment, difficult child temperament and hostile biased social cognitions are repeatedly associated with aggressive behavior in children. Poorly adjusted family members can spoil family environment.

PERCEIVED PARENTAL HEALTH ORIENTATION

Perceived parental health orientation refers to the emphasis parents give on health.

Review of Related Studies

Personality and Health Protective Behavior

Chattopadhyay et al., (1979) administered the self evaluation questionnaire to 80 subjects (mean age 30 years) with psychosomatic disorders and controls. Anxiety seemed to be primarily due to subjects’ apprehension of a serious illness.

According to Holahan and Moss (1986), previous research has indicated that there is a relation between Extraversion and Subjective Well-Being (SWB), and that the sociability component of Extraversion primarily accounts for this relation.

Ryff (1989) found that extraverts reported better psychological adjustment than introverts. Need for social approval and gender of the participants were unrelated to self-report of well-being. Satisfaction with social activities, especially activities involving friends, parents, predicted psychological well-being, but the ‘frequency of social activity did not. In
another study, internal locus of control, high desire for control, and being female, as well as perceived control over the testing situation, were found to predict better psychological adjustment and health.

According to Robert et al., (1991), Neuroticism, Extraversion, and Openness to experience have been shown to have systematic effects on psychological well-being and health. The remaining dimensions in the five-factor model of personality – Agreeableness and Conscientiousness – may contribute to increase life satisfaction and happiness. Self-reports and spouse ratings on the NEO Personality Inventory, a measure of the five factors, were correlated with three measures of psychological well-being in the sample of 429 adult men and women. Consistent with previous research, Neuroticism was negatively and extraversion was positively related to well-being. Both Agreeableness and Conscientiousness were also significant independent predictors. Thus, personality dispositions appear to have temperamental, experimental, and instrumental effects on psychological well-being and health (Robert et al., 1991).

Mohan et al., (1996) investigated perceived health status among adolescents in relation to their personality, perceived control, daily hassles, and attitudes. Results showed sex differences and role of personality and stress in health status of adolescents.

DeNeve and Cooper (1998) found that Extraversion and agreeableness predicted positive affect reliably. Also they found that a low level of neuroticism was the strongest predictor of life satisfaction and happiness and of a low level of negative affect.

The Health Locus of Control is a personality variable directly related with health. People who score more towards the ‘internal’ direction seem to be more achievement-oriented and less conforming and complaint, more intelligent (Strickland, 1977). People who are internally-oriented handle threatening situations effectively. On the other hand, externally oriented people may be sensitive to factors in a situation that
might interfere or block their efforts. Such people may be first to perceive obstacle and may be better able to cope effectively with them (Phares, 1976). Hence internals are more keen to make efforts to combat disease while externals feel no sense of control over what is happening to them (Mohan, 2000b).

A study of life stress among American high school students (Cauce et al., 1992) found that those classified as ‘internals’ were better adjusted in terms of anxiety, as well as general, school, and physical competencies, than were ‘externals’. Thus, a sense of control acts as a buffer against stressful experiences by reducing student’s anxiety, thereby helping them to maintain adequate levels of competency.

People with an internal locus of control believe that they can influence their health, but people with an external locus of control believe that it does not matter what they do, others or fate will decide. Bosma et al., (1999) found that external locus of control, neuroticism and absence of active problem focused coping explained almost fifty percent of the variation in self rated poor health.

Opara (1999) reported that healthy controls scored higher than cardiovascular diseased patients on Trait Anxiety.

The personality construct of hardiness has been shown to play a significant role buffering the effects of stress and promoting health.

Kobasa (1979, 1982) reported that a hardy individual possesses a strong sense of control, commitment and challenge, which act together to help buffer the debilitation effects of life stresses, such as physical illness.

Hardiness was originally conceived to improve health by existing as a buffer of stressful life events (Kobasa and Puccetti, 1983). In highly stressful environments, hardy individuals were proposed not to fall ill because of their feeling of commitment, control, and challenge.

Rhodewalt and Agustsdottir (1984) also investigated how hardy individuals perceive life events. The hardy individual do not experience life
events that are qualitatively different from those experienced by nonhardy individuals, but they are more likely to perceive the events they do experience as positive and themselves as in control. If hardy individual perceive events as uncontrollable or as moderately controllable and undesirable, they also show psychological distress. They are simply less likely than nonhardy individuals to perceive events in such terms. This pre-disposition is health promoting

Defined the three components of hardiness, Maddi (1990) opined, “Persons high in commitment think of themselves and their environments as interesting and worthwhile and thus can find something in whatever they are doing that appeals to their curiosity and seems meaningful. Persons high in control believe that they can through efforts have an influence on what goes on around them. And persons high in challenge believe that what improves their lives is through learning rather than easy comfort and security”.

Westman (1990) has also found the notion agreeable that “hardiness operates as a stress buffer as well as a direct influence on health”.

Ouellette (1993) also proposed “hardiness acts as a stress buffer when people have high levels of all three components”. (Control, Commitment and Challenge).

According to Sinclair and Tetrick (2000), personality dimension of hardiness not only influences stress appraisal and hence transformational coping directly, but also through its influence on social support, hardy people seek the kind of social relationships that support transformational coping in times of stress, whereas people low in hardiness do the opposite, thus perpetuating their tendency towards regressive coping. Social support has a complicated role in the relationship between stressful events and illness.
According to Greenberg (2003), personality is habitual behavior measured by mental attitudes and physical activities. Efficacy is a mental attitude needed for engagement, that is, the efficacious person feels that he/she has an opportunity to make a difference in their own health, as well as the health of their neighborhood. In contrast, unless they are desperate, it is highly unlikely that a person who feels helpless would engage in many activities to protect their own health or the health of their neighborhood. The literature in support of this proposition is strong. Efficacious people tend to recover from surgery more rapidly, are more likely to successfully recover from alcoholism, and are more likely to achieve a variety of other beneficial individual health outcomes (Pearlin et al., 1981; Stone and Neale, 1984; Scheier and Carver, 1985; Folkman and Lazarus, 1988; Lin and Peterson, 1990; Lazarus, 1991 and Furnham and Steele, 1993). A parallel, but much smaller literature shows that people with a strong sense of mastery are likely to engage in civic activities (Greenberg, 1999, 2000, 2001).

Jacob and Dodd (2003) evaluated the relative influences of intrapersonal factors, interpersonal factors, and workload on psychological burnout. Results suggested that personality, especially negative temperament, may predispose college students to burnout, whereas social support, especially from friends, may provide an important buffer against burnout.

Positive temperament has been found to be positively correlated with personal accomplishment, replicating previous findings (Mills and Huebner, 1998 and Zellars et al., 2000). Positive traits such as optimism and energy may act as a buffer to the stressors and frustration that can lead to dissatisfaction with one’s personal accomplishments.
Positive and Negative Mental States and Health Protective Behavior

Veenhonen (1984) reported that people who perceived themselves to be happy led a healthy life and enjoyed higher quality of life. People, who were high on trust showed a belief in conventional goodness, were moralistic and altruistic, and had high self-esteem and scored higher on optimism (Wrightsman, 1992).

Scheier and Carver (1985) investigated whether dispositional optimism acts as a buffer against stress. They found that optimism positively correlated with indices of active coping with elaboration or complexity of coping strategies, and with seeking of social support. Optimism was negatively correlated with focus on emotional and emotional expression and with disengagement from the goal.

Vantrenren and Hull (1986) suggested that optimists show less cardiovascular reactivity to stress.

Scheier and Carver (1987) have suggested that differences in well-being between optimists and pessimists could derive from the way individuals select and use the general strategies of coping available to them. The second possibility is that optimism/pessimism differences directly affect physiologic functioning.

Aspinwall and Taylor (1992) assessed optimism and coping in a group of students entering college and assessed well-being three months later. In this case, the beneficial effects of optimism appeared to operate at least in part through differences in both active coping and avoidance coping. Optimists receive greater satisfaction from interpersonal relationships and perceive lesser stress and are better at coping. Compared to pessimists, optimists report greater satisfaction from relationships with friends, have lower levels of distress, are less depressed, have less perceived stress, and have higher social support.
(Scheier and Carver, 1992). Therefore, optimists have better mental and physical health.

Opara (1999) reported that healthy controls scored higher than cardiovascular disease patients on Optimism and Well-Being.

Byrne and Mazanov (1999) studied Swiss teenagers, who were asked about their future health, their negative emotions, and their well-being. On the basis of their self-reports, they were divided into 3 types of drug users: non-users, experimenters, and frequent users. Compared with nonusers, experimenters, and frequent users reported low optimism and more negative feelings. Females reported more negative feelings and less psychological well-being than did males, but the genders did not differ regarding optimism. Logistic regression demonstrated that optimism about future health was a protective factor for the intention to use drugs. Students who perceived themselves as less vulnerable to harm had in the past not used drugs and intended not to accept drugs when given the occasion.

There is a quite a lot of evidence that happiness can influence health directly, i.e. cause health, referring now to health which is objectively measured. Deeg and Zonneveld (1989) studied 3149 Dutch people aged 65 or over, and controlling for a range of demographic variables, found that happier individuals lived longer. Evans and Egerton (1992) found that negative moods lead to more colds. The explanation for these findings may be through the effect of mood on the immune system. Stone et al., (1987) found that while negative moods produced, lower immune system scores, good moods elevate them. Devins et al., (1990) found that happiness and regular leisure predicted better health.

According to Hamilton and Fagot (1988), individuals who suffer from poor health may be so preoccupied with their own problems that they have neither the time nor the psychological energy to attend the problems external to the self or to extensions of self. Those enjoying positive health
are less self preoccupied and are therefore able to attend to problems in the society and world around them that concerns the welfare of others.

According to Cohen and Williamson (1998) persons experiencing negative affect like irritability, hostility often engaged in poor health practices which have immunosuppressive effects and reduce their bodies' ability to fight other illnesses.

**Stress, Coping and Health Protective Behavior**

The psychological stressful events run to strain and from there to illness. As the psychological stressful events mount, (job loss, marriage, a child leaving home, a worsening financial condition), signs of strain increase. This strain can show itself physically by sweaty palms, rapid heartbeat, chest pains and psychologically by irritability, anxiety, loss of appetite. These signs indicate that, if prolonged, can lead to physical breakdown in the form of define illnesses. Illnesses related to stress can be minor or major, physical or mental.

Shanan (1976) illustrated the way people cope with situations in which they have no control over the outcomes. The authors assumed that people who are repeatedly in uncontrollable situations experience helplessness and become increasingly passive in their coping efforts, and ultimately experience demoralization, depression and illness. Many life situations also pose grave psychological threats like evaluation anxiety (Krohne and Laux, 1982) and loneliness (Jones, 1982; Solano, 1982 and Schultz and Moore, 1984). These researchers evaluated the ways in which people cope with situations that threaten their self-esteem and concluded that, any relation found between coping and long term outcomes was probably due to the person's repeatedly experiencing stressful situations that touch on a particular area of vulnerability, insofar as a single, isolated instance of poor coping was not likely to have long term implications for health and well-being.
Compas et al., (1986) examined relationship among major life events, perceived social support, and psychological disorders in a sample of older adolescents. Negative life events and satisfaction with social support were significantly and independently related to self-reported attractiveness, likeability, happiness, life satisfaction and health status.

Cheng et al., (1993) conducted a cross-cultural investigation on determinants of headache and reviewed literature from 1937 to 1987 to examine age, gender and stress factors; headache characteristics; and modalities of pain control in adult headache with inference for their significance in childhood headache. Four major conclusions were reached: firstly, the prevalence of migraine increases from approximately 7% in children to 11.5% in adults; secondly, more than 60% of patients report severe headache in a trend that is consistent across nations, with females reporting greater severity than males; thirdly, physical and psychological stressors appear to be the major precipitating factors of headache; fourthly, while medication is the most commonly used form of treatment, rest and relaxation appeared to be the important coping mechanisms for headache.

De-Goede et al., (1999) examined the effects of stressors in both the vocational and relationship areas and on adolescent mental health. Career stressors, and stressors in the relationship domain, appeared to have significant long term effects on adolescent mental health. Vocational and relationship identity formation were also significant predictors for adolescent mental health.

There has been a substantial amount of research in college students and its relationship with health behaviors (Weidner et al., 1996), anxiety concerning exams (Everson et al., 1993 and Abouserie, 1994), self-esteem (Abouserie, 1994 and Newby-Fraser and Schlebusch, 1997), and coping strategies that students use (Dwyer and Cummings, 2001).
Mohan and Sehgal (2000) conducted a study to assess stress, coping and health cognitions among adolescents. They opined that adolescence is the most turbulent challenging and stressful period. Teenage years have been recognized as crucial for later emotional physical health. From the point of view of health, adolescence is an important period because during this phase, a number of health compromising behavior may emerged (e.g., smoking, drinking, taking drugs, and practicing unsafe sex). The study focused on measuring health and illness cognitions among adolescents. In addition their perception of stressors and coping and their relationship with personality and health status was explored. 200 adolescence (15-18 years) half from each gender comprised the sample. They were administered HLOC Scale, Daily Hassles inventory, and rating scale to assess health status. Results revealed that internality was negatively related with health status and stress experienced. There was a clear difference in the health practices of internal and external adolescents. The findings revealed that daily hassle may impact adolescents’ health negatively whereas, internality may promote health related behavior.

Mental Health, Psychological Well-Being, Perceived Social Support and Health Protective Behavior

Berkamn and Syme (1970) conducted a study among the residents of Alamenda Country, California, over a nine year period. They found that people who initially had very poor health were indeed a little less likely than others to have friends and social contacts.

Caplan (1981) noticed that provision of emotional support bolsters the feelings of control and self worth leading to better health.

Dhoundiyal (1984) studied the effect of home environment on the emotional disturbance among adolescents. In general, it was revealed that poor home environment led to significantly more frequent occurrences of emotional disturbances among teenagers.
Many findings affirm that people who are well supported have a better chance of staying alive and healthy than those who lack support. (Blumenthal and Berg, 1987).

Ganster and Victor (1988) emphasized that the degree of stress experienced may be related to perceived social support. Social support has been defined as the presence of others, or the resources provided by them before and during and following a stressful event. Social support has been shown to have a beneficial effect on mental health. Schwarzer and Leppin (1989) reviewed a large number of studies. They concluded that it was not always clear how the social support had its effect. It could have been the perceived social support, which is whether the individual felt that they were getting the attention that they should.

Aaronson (1989) and Treiber et al., (1991) opined that social connections can provide specific support for engaging in health promoting behaviors. Individuals who report receiving more support for given health-related behaviors are likely to engage in those behaviors.

Krause (1991) reported that perceived health problems are predicted to erode feelings of life satisfaction through time. These deleterious effects are thoughts to be offset or reduced because one seeks out and receives support from members of one's informal networks as well as assistance from formal sources. Krause and Clark (1994) suggested that supportive social relationships help people to cope effectively with an almost unlimited range of problems and difficulties.

Clara et al., (1994) administered an adolescent health survey on students with a variety of chronic conditions and without chronic conditions to determine emotional well-being, worries and concerns, and body image. Subjects with chronic conditions had lower emotional well-being scores, worried more about dying soon and about school or future work, and had poorer body image. For all the subjects, higher emotional well being scores were significantly related to higher levels of family connectedness.
The best explanatory variables of emotional well-being were body image, family connectedness, concerns about school and future work, having a disability, and worry about peer relationships, accounting together for 36% of the variance in the outcome variable.

Jacobs and Dodd (2003) found that social support, especially from friends, is closely related to lower levels of burnout. Specifically, higher social support from friends was associated with lower levels of depersonalization and higher levels of personal accomplishment, a replication of the findings of Koniarek and Dudek (1996). In fact, all three forms of support (friends, family, and significant other) appear to be intercorrelated, both in the current study and as reported by Zimet et al., (1988). Further analysis of first-order correlations revealed that all three measures of burnout: Greater social support was associated with less emotional exhaustion, less depersonalization, and a greater sense of personal accomplishment and consequently with greater health.

It is often said that mental health is full and harmonious functioning of the whole personality, which gives satisfaction to the person and is beneficial to the society. It is a positive concept and not mere absence of disease. General well-being is a part of this positive mental health. Though the subjective feeling of well-being is difficult to fathom and measure, the concept continues to be useful in mental health research.

Berkman and Glass (2000) found that there is an independent association between lack of social support and morality. Social isolation has an adverse impact on health. Social support may have the potential of increasing host resistance and of thereby improving human health and well-being.

Social ties enhance the immune system’s ability to prevent and heal illness. Just as exercise conditions our muscles to handle heavier loads, social interactions condition the immune system so we experience less illness and recover more quickly from diseases we can’t avoid.
According to King (1998) and Cohen (2000), physically being with other people can help in oblivious cooperative ways, but ‘social support’ implies something beyond this. Human beings are thinking, remembering, and imagining animals. Whether someone is well supported or not must be regarded as a state of mind that is carried forward from actual physical encounters with others into the rest of the person’s life. Rites and rituals for the expression of social support are not the exclusive property of primitive cultures. In the modern developed world the family may no longer be the pivotal basis of social interaction that is once was, but it is far from extinct and its influence can still be potent.

According to Kim (2003), adolescents suffer emotional and mental health problems, and such turmoil is very often carried over into adulthood with serious implications for adjustment during the post-adolescent years. Kim (2003) found that mental health problems are crucial factors in the health status of adolescents in Korea; he conducted a study to investigate mental health problems in Korean adolescents, to reveal factors affecting their negative mental health and relations between mental health problems and psychological variables. The results showed high prevalence in the areas of interpersonal sensitivity, depression, anxiety, and hostility.

The WHO has also declared health as a state of physical, psychological and spiritual well-being (WHO, 1985, cf. Verma et al., 1989). Well being is a person’s evaluations of his or her life either in terms of life satisfaction (Cognitive evaluations) or affects (on going emotional reactions). Verma and Verma (1989) defined psychological Well Being as the subjective feeling of contentment, happiness, satisfaction with life experiences and of one’s role in the world of work, sense of achievement, utility; belongingness and absence of distress, dissatisfaction or worry. Well-being is now the focus of intense research attention (Diener and Diener, 1995) as a correlate of health.
According to Johnson and Sarason (1978, 1979) and Syme (1979) people who have ‘Close Others’ to rely upon during stressful experiences can cope more effectively and keep away from negative psychological or health outcomes.


Well-being involves global evaluations of affect and life-quality and examines perceived thriving vis-à-vis the existential challenges of life (Kozma, 1996). Suh et al., (1996) found that the impact of positive and negative life events on well being was brief but there is some evidence that Well-Being is affected by the impact of the events (Heady and Wearing, 1989).

That there ought to be an association between health status and well-being seems intuitively clear. Sickness is often associated with displeasure or pain, so the presence of illness might directly increase negative affect (Mohan, 2001a).

Ryan and Deci's (2001) integrative review organized the field of well-being into two broad traditions: one dealing with happiness (hedonic well-being), and one dealing with human potential (eudemonic well-being). Ryan and Deci (2001) opined that the concept of well-being refers to optimal psychological functioning and experience.

Self-esteem, Self-Efficacy, Health Habits, and Health Protective Behavior

Coopersmith (1968) found that people low in self-esteem face frequent problems for example, destructiveness, feelings of discouragement towards themselves and insecurity in social interactions. This makes them more disease prone.
Self-Esteem is defined as the way one feels about oneself including the degree to which one possesses self-regard and self-acceptance. In other words, it is an attitude of self-approval (Buss, 1978).

Self-Esteem is a psychological construct that has, since the times of William James been associated with mental and physical health (Kendler et al., 1998). Low levels of Self-Esteem have been associated with substance abuse (Bry et al., 1982) anxiety disorders (Ingham et al., 1986), major depression, and poor general health (Hunter et al., 1981).

Global and domain specific self-esteem has been shown to influence a significant number of psychological and behavioral variables in children and adolescents. Self-Esteem has been negatively correlated with smoking frequency (Botvin et al., 1993), suppressed anger (Unger et al., 1997) and depression symptomatology (Caldwell et al., 1997) in Africa American college students who had alcoholic parents (Rodney and Rodney, 1996). Thus, self-esteem is an important index of one’s well-being.

Pearlin and Schooler (1978) described self-esteem, as a psychological resource that influences stress and coping processes. Pearlin et al., (1981) found that persons with high self-esteem reported less depression in the face of job loss than do persons with low self-esteem. There appears to be a significant relationship between self-esteem and certain basic behavioral aspects including health behavior.

Campbell et al., (1976) found that self-esteem was the strongest predictor of life satisfaction in a national sample of adults in U.S. Through the years, self esteem has been linked to a wide variety of social psychological outcomes including conformity (Brockner, 1984), persuasion (Rhodes and Wood, 1992) and subjective well being (Diener and Diener, 1995). All these behaviors have implications for a person's health status. Strassberg and Robinson (1974) reported that internality was associated with higher levels of self-esteem and with better
psychological adjustment. Nisha (1990) found self-esteem to be negatively correlated with stress in adolescents.

West and Prinz (1987) found that lower self-esteem, along with low internal locus of control, emotional, psychiatric and adjustment disorders are likely contributors to depression. Similarly, Ayers et al., (1996) found that self-esteem is negatively related with stress and positively to health.

Brown and McGill (1989) reported that after experiencing positive life events, students with low self-esteem reported with lower physical well-being.

In a study of a smoking control program, Condiotte and Lichenstein (1982) found that self-efficacy predicted which smoker would relapse, how soon they would relapse, and in what situations relapse was likely to occur. If they started smoking again, those who were high in self-efficacy were more likely to try again to give up than those who were low in self-efficacy.

Research generally suggests that human functioning is facilitated by a personal sense of control (Schwarzer, 1992) and self-efficacy beliefs represent one aspect of such a sense of control. People with high self-efficacy beliefs are better able to cope with stress and disappointments than are individuals with low self-efficacy beliefs.

Many of our health habits are established in early life including dietary patterns, cigarette smoking, alcohol consumption, personal hygiene and exercise. It has also been established that health related behaviors constitute a pathway by which environmental factors (stress, social support) and dispositional factors (personality, temperament, attitude, and coping style) affect disease risk and health status.

Schoenborn (1993) found the association between health status and seven aspects of lifestyles – hours of sleep, eating breakfast, snacking, physical activity, alcohol consumption, cigarette smoking and relative weight.
Narring et al., (1993) did a study whose main objective was to explore adolescent health attitudes and behavior as well as health needs. They found that girls exhibited a tendency towards more perceived health problems and more use of health care structures, whereas boys express their problems in a more "external" way, i.e. violent behavior (injuries, fighting, theft, etc.)

Lawrence and Schank (1993) did a study whose data revealed that the lifestyles of many respondents were not conducive to promoting or maintaining health. Negative health practices identified were drinking and driving, non-performance of self breast examinations, ineffective stress management strategies and poor dietary and exercise habits.

Heaven (1996) listed some of the psychological benefits that flow from physical fitness. These include such features as feeling more positive about oneself, reducing depression, helping to reduce hostile behavior in oneself and so forth. Thus, as Harris (1991) has argued, that there are many benefits to being physically active. Indeed, she stresses that one cannot afford not to exercise. It is thought that physical exercise remains the only constant factor in the teenager's world, which is subject to biological, emotional, and cognitive change. Regular exercise also has some discernable physical benefits.

Heaven (1996) said that there is at least one compelling reason for adolescents to maintain a healthy and balanced diet and that is because of the growth spurt. There are gender differences, however, with boys tending to gain more muscle than girls who, in turn, gain more fat. Teenagers perceive certain barriers to improving their nutrient intake. These are lack of time, the view that eating properly is inconvenient, and the lack of a sense of urgency. As regards attitude formation towards diet and nutritional issues, teenagers absorb parental values about a wide range of important health issues and so family experience is vital.
Interestingly, some evidence suggests that this might be the case for males, but not for females.

Some studies were also conducted with Health Protective Behavior and many of these variables taken together.

Nowack (1989) conducted the study on 194 professional employees to investigate the effects of measures of coping styles (intrusive positive thoughts, intrusive negative thoughts, avoidance, problem-focused coping), cognitive hardiness, stress, health habits, psychological distress and physical illness. Results revealed that intrusive negative thoughts and avoidance coping approaches significantly contributed to predictions of psychological distress and physical illness outcomes respectively. Cognitive hardiness significantly contributed to predictions of psychological distress but not to physical illness. Health habits were significantly related to both measures of health status. Intrusive positive thoughts and problem-focused coping, did not significantly contribute to predictions of either physical or psychological status.

Victor et al., (1995) studied 276 Israeli recruits on hardiness, mental health, cognitive appraisal, and ways of coping at the beginning and end of a demanding 4-month training period. Results showed that two components of hardiness – commitment and control predicted mental health, measuring from the beginning to the end of training through the mediation of appraisal and coping variables. Commitment improved mental health by reducing the appraisal of impact and the use of emotion-focused strategies and by increasing secondary appraisal. Control improved mental health by reducing the appraisal of threat and by increasing secondary appraisal and the use of problem-solving and support-seeking strategies.

Sumi (1997) conducted a study on 176 Japanese female college students. The relationship between optimism, social support, and stress
and on physical and psychological well-being was examined. The results showed that individuals with higher optimism and social support were higher on physical and psychological well-being regardless of their reported stress.

Kagee and Dixon (2000) re-examined Pepper’s (1942) theory of health promoting behavior. They conducted the study on 259 subjects who were measured on worldview, health promoting behavior (HPB), social class, and sex. Results showed that a modest relationship existed between worldwide and HPB with organismic thinkers more likely than mechanistic thinkers to engage in HPB. There was also a slight indirect effect of sex on worldview and HPB, with women more likely to endorse an organismic worldview and therefore more likely to engage in HPB than men. No relationship was found between socioeconomic status and HPB.

Nathawat (2000) studied the influence of hardiness and social support on some measures of psychological well-being among educated old men. Results revealed that hardiness and social support significantly influenced psychological well-being in educated elderly men. Hardy aged men had significantly better psychological well-being than low hardy or non-hardy aged men. Also, aged men with high social support had better psychological well-being than the aged with low social support. Hardiness was a good predictor of psychological well-being as most of the measures of psychological well-being were significantly influenced by hardiness.

Piko (2000) examined 691 students to study the intercorrelations of a number of psychological and health-related variables with special emphasis on the predictors of self-perception of health using stepwise linear regression analysis. Results showed that psychological well-being played a central part in determining self-perceived health. Four health related behaviors; psychological well-being, physical activity behavior, acute illness episodes, and frequency of psychosomatic symptoms
contributed significantly to the self-perception of health. Some differences were detected between the type and the number of contributing factors among the subgroups by sex and physical activity behavior (i.e. physical activity was far more influential among males and likewise among more active persons) psychological well-being proved to be the strongest predictor. Physical activity behavior correlated positively and the frequency of psychosomatic symptoms correlated negatively with psychological well-being.

Takakura and Sakihara (2000) inferred that for depressive symptoms of students, life stresses might be risk factors but positive health practices, social support, high self-esteem and internal locus of control might be protective factors.

The components of self-perceived health in a young sample are different from those in adults and in older people opined Krause and Clark (1994). In their research, the stepwise linear regression analysis revealed that four of the health-related variables under study contributed significantly to the self-assessment of health; psychological well-being, physical activity behavior, acute illness and the frequency of some common psychosomatic symptoms. As it is argued in other studies, the younger age groups were more likely to use health behaviors and psychological well-being as a frame of reference, while in the older age groups self-rating principally reflected physical health problems. In a study of a larger sample of college students, perceptions of poor health were also associated with reports of greater psychophysiological distress and symptoms like depression and performance difficulties in daily activities (Eberst, 1984). The results suggest that psychological well-being plays a central role in self-perceived health. Finally, they concluded that in the student population self-perceived health was mostly related to the psychological dimension of health (psychological well-being, psychosomatic symptoms) but objective symptoms (acute illness
episodes) and health behaviors (e.g., physical activity behavior) were also significant predictors. Results of this study may be applied to the development of a health promotion program for the students emphasizing sports participation as a tool of maintaining mental health.

Wolff et al., (2000) investigated differences between binge eaters and controls on daily stress, coping, mood, and eating behavior. All these variables were also used to compare binge and non binge days for the binge group. The sample consisted of 20 college women who reported binge eating and 20 who reported no disturbance. Subjects were asked to self-monitor on these variables for 3 weeks. They found that binge group reported more stress and negative moods than the control group, and experienced similar stressful events on binge days as compared to non binge days, however the impact of stress was much greater on binge days. The binge eaters had less positive moods and more episodes of eating on binge days. Both binge and non-binge groups used similar coping strategies. Stress and negative mood states were common for binge eating.

Sourander et al., (2001) examined the associations of parent, teacher and self-report evaluations of child psychopathology, help-seeking variables and family factors with the use of child mental health services. The study was an 8-year follow-up of 857 children from age 8-16 years. Results revealed that the most potent predictors at age 8 of later referral were total problem behaviors and antisocial problems in parental evaluation, teachers’ evaluation of the child’s need for referral and living in other than a biological two-parent family. At age 16, externalizing and internalizing problems, total competence, and family composition were independently associated with use of mental health services.

McNicholas (2002) studied the relationships between positive health practices and social support, self-esteem, and optimism. 202 middle-age adults were selected as sample. Social support, self-esteem,
and optimism were positively related to positive health practices and social support was positively related to self-esteem and optimism.

**Maxwell (2002)** examined peer influence across five risk behaviors: cigarette smoking, alcohol consumption, marijuana use, tobacco chewing, and sexual debut. 1969 adolescents aged 12-18 years were selected in the sample. Results revealed that a random same sex peer predicted a teen's health risk behavior initiation; there is influence only to initiate cigarette and marijuana use; and that here is influence to initiate and stop alcohol and chewing tobacco use. Findings also suggested that friends protected adolescents from health risk activities.

**Bal et al., (2003)** investigated the role of social support in well-being and coping after a stressful event on non-clinical adolescents. The study also aimed at replicating the findings in sexually abused adolescents who reported more symptoms and less adequate coping strategies than adolescents who reported another type of stressful event/no stressful episode. 820 adolescents between 12-18 years were assessed on social support, trauma symptom, behavior problems and coping. The results revealed 42% of adolescents reported a stressful experience and 4.4% reported sexual abuse. Sexually abused adolescents reported more stress related symptoms and used more avoidance and few support-seeking coping strategies than other adolescents. Social support did not affect the relation between stressful events and coping. Also support from the family was associated with less avoidance coping and more support-seeking, in adolescents reporting non-sexual abuse. Highly perceived availability of social support was related with fewer trauma related symptoms in adolescents.

**Pritchard and Wilson (2003)** studied students' emotional health (e.g. depression, stress, perfectionism) impact on students' General Perceptual Ability and retention and also students' social health (e.g. membership in campus organizations, extraversion, alcohol use) impact
on students' General Perceptual Ability and retention. Study was conducted on 218 college students. Results revealed that both emotional and social health factors related to student performance and retention. Students' emotional health was significantly related to General Perceptual Ability regardless of gender. Social health factors did not predict intent to drop out and they had less of an impact than did emotional health on student performance. Members of student academic honors organizations had higher General Perceptual Abilities' than those not in an academic organization. Thus, no single factor or set of factors (e.g. demographic, academic, social, emotional) that predict individual student success or retention. It appeared that there are a multitude of factors that influence the way students adjust to college.

Bovier et al., (2004) viewed Mental Health as the main determinant of quality of life. They surveyed 2000 university students to study the role of perceived stress, social support, and internal resources as determinant of health. The tests used were, the Brief Encounter Psychosocial Instrument to measure Perceived Stress. Social Support by Duke-UNC Functional Social Support Questionnaire, Internal Resources (Mastery and Self-esteem) by a brief version of the Pearlin Coping Questionnaire. Results revealed Mental Health was negatively associated with Stress and positively with Social Support and Internal Resources. Mastery and Self-esteem were positively related with Mental Health and buffered negative impact of stress. Thus, it was concluded that perceived stress is an important risk factor for low mental health and self-esteem are important protective factors of mental health among young adults.

Oppedal and Roysamb (2004) investigated differences in levels of mental health, life stress, and social support with immigrant and domestic background adolescents. Also, to identify culture group and gender specific sources of risk and protective factors and their relation to mental health, sample consisted of 633 students for Norway aged 13 years.
Results revealed higher level of psychological distress and lower social support among immigrant than host students. In gender-culture group, immigrant boys reported the highest level of problems, with 28% prevalence of anxiety/depression. While girls showed no significant differences. Relationship between life stress, social support, and mental health were found across culture and gender.