CHAPTER 1

INTRODUCTION
CHAPTER – ONE

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LIFE SATISFACTION

Satisfaction is a central concept to research on psychological well-being. Within this context, the study of the relationships between satisfaction with life as a whole and satisfaction with specific life domains (family, job, health, leisure, friendships, etc.) or life facets has been a widespread and common approach to psychological well-being since it was first described by Andrews & Whitney (1976). There is considerable agreement among authors that the study of these relationships is important for the better understanding of the structure of psychological well-being (Diener & Lucas, 1992). There even exists a certain consensus in accepting the gestalt principle that satisfaction with life as whole is something more than the sum of its parts, that is to say satisfaction with different domains in life (Veenhoven, 1994).

Since the 1980s, there has been a dramatic increase in research on well-being, with most researchers agreeing that feelings of well-being comprised of a cognitive-evaluative factor (life satisfaction) and an affective factor (happiness) (Andrews & Whitney, 1976; Campbell, 1981; and Emmons & Diener, 1985). More specifically, satisfaction is more of a cognitive evaluation that is particularly dependent on social comparisons with other important reference groups as well as individual's desires, expectations and hopes. In contrast, happiness is conceived as an emotional state produced by positive and negative events and experiences in the life of an individual. Although there is some empirical correlation, in varying degrees, between happiness and life satisfaction, they are nevertheless distinct (Gitmez & Morcol, 1994; and Tsou & Liu, 2001)

Life satisfaction is considered to be a central aspect of human welfare. It is the ultimate goal, and human beings strive to achieve this goal throughout their
lives. Satisfaction with one's life implies acceptance of life circumstances and the fulfillment of wants and needs for life as a whole (Webster's Dictionary, 1996). It is generally referred to as an assessment of the overall conditions of existence as derived from a comparison of one's aspirations to one's actual achievements. It can also be defined as having a favourable attitude towards life.

There are two types of satisfaction, whole or global life satisfaction and life domain satisfaction (Argyle, 2001; and Salvatore & Munoz, 2001). Life domain satisfaction refers to satisfaction within specific areas of an individual's life such as marriage, education, job, income, etc., whereas global life satisfaction is a broad concept which includes one's judgment of life as a whole. People rely on domain satisfaction information when they evaluate their whole life events (Schwarz & Strack, 1991).

A feeling of satisfaction with life is an important factor for a general sense of well-being (Neugarten, 1982). Life satisfaction often refers to the attitudes that individuals have about their past, present as well as future in relation to their psychological well-being (Chadha & Willigen, 1995). Furthermore, life satisfaction is a situation or a consequence obtained through comparing someone's expectations (whatever desired) with possessions (whatever gained). When life satisfaction is addressed, generally a satisfaction related to whole life experience is understood, rather than the satisfaction pertaining to certain conditions.

Research has indicated that the concept of life satisfaction is elusive, and can be highly susceptible to one's own social values or judgments about important aspects of life. However, this concept has psychological as well as social implications. Firstly, it implies the personal contentment with life and positive self-regard for an individual. Secondly, it includes a personal appraisal of fulfilling one's social roles.

Life satisfaction by nature is a subjective measure. It is different from happiness, which represents a positive state of emotion at a single point in time.
Instead, life satisfaction reflects a collective experience or how a person feels about their life as a whole over the long-term, rather than right now.

Life satisfaction is associated with a general feeling of cheerfulness and enthusiasm. It is an indicator of a person’s overall degree of emotional intelligence and emotional functioning. A satisfied person often feels good and at ease in both work and leisure in his life. In contrast, a dissatisfied person demonstrates symptoms of depression, such as a tendency to worry, uncertainty about the future, social withdrawal, lack of drive, depressive thought, a feeling of guilt and in extreme cases suicidal thoughts and behaviour.

Recently, Shankar (2013) has characterized two kinds of mind viz. right-ended null mind and left ended null mind. The right ended null mind always enjoys equilibrium in life satisfaction. Any dissatisfaction of life to a person possessing right-ended null mind is also a life satisfaction of the intensity or degree zero. On the other hand, a left-ended null mind always perceives nonequilibrium in life satisfaction. Any amount of life satisfaction to a person possessing left-ended mind is real, a life dissatisfaction of degree or intensity zero. Philosophically, there is only equilibrium or nonequilibrium in life satisfaction. Technically speaking there is no attributive mechanism of life satisfaction or dissatisfaction; it is only a perception and status of mind.

The "threshold" approach suggests that overall life satisfaction depends on the presence of some threshold number of satisfactions. If the number of domains with which one is satisfied does not meet this threshold, the person would not feel satisfied with life as a whole. The "ceiling" approach suggests that there is a top limit or ceiling to the number of domain satisfactions experienced by an individual, and satisfaction with domains beyond the top limit would not produce increased satisfaction with life as a whole (Campbell et al., 1976; and Inglehart, 1978).

Life satisfaction can be defined as the cognitive component of subjective well-being (Martikainen, 2008). This is consistent with Bradley & Corwyn (2004) who
asserts that life satisfaction reflects both the extent to which basic needs are met, and the extent to which a variety of other goals are viewed as attainable. From this perspective, it seems reasonable to believe that by accomplishing more goals, satisfaction with life will also increase. According to Beutell (2006), it is believed that life satisfaction is related to better physical, and mental health, longevity, and other outcomes that are considered positive in nature. In addition, Chow (2009) argues that improved levels of life satisfaction might give rise to better health in the future.

Importance of life satisfaction not only as an outcome, but also as a predictor in health research is documented by its predictive value with regard to physical health and even mortality. Regarding predictors of life satisfaction, evidence repeatedly pointed to a seemingly paradox phenomenon. Individuals usually rate their living and health conditions as being better than one would assume given their objective status. Only low correlations between objective circumstances and subjective life satisfaction are found. This phenomenon is referred to as the "well-being paradox".

A study investigating differences in life satisfaction among patients with different medical diagnoses and healthy controls showed that patients with a functional dyspepsia reported lower life satisfaction than stomach-cancer patients. The best life satisfaction scores were those of cancer patients in rehabilitation programs. It has been often replicated that illness is not necessarily associated with low life satisfaction. Many studies have revealed a high percentage of satisfied individuals even among persons who clearly have severe health problems.

Satisfied person often feels good and at ease in both work and leisure in his life. In contrast, a dissatisfied person demonstrates symptoms of depression, such as a tendency to worry, uncertainty about the future, social withdrawal, lack of drive, depressive thought, a feeling of guilt, and in extreme cases suicidal thoughts and behaviour.
BASIC MODELS

Initially, two basically different models were formulated. The first model assumed that the life-satisfaction of a person depended mainly on turns in life, while the second model assumed that life-satisfaction depended also on the person's stable stocks. Both models fit Veenhoven's view of the life-appraisal process, in which life-satisfaction results from the stream of daily events. When nice things happen to people all the time they feel good, when odious things happen they feel bad. Life-satisfaction reflects the balance of affective experience over a certain period (Veenhoven, 1997). Likewise, Kahneman (1999) recently described life-satisfaction as 'remembered instant utilities'.

(1) Bottom-Up Model

In the first model, the stream of gratifying experiences, and hence life-satisfaction, depends on the course of life. If life changes to the better, the stream of nice events grows, and hence the number of positive experiences. For instance, when one gets married one becomes typically more comfortable at breakfast and less lonely at dinner. On the other hand, a turn to the worse reduces the number of uplifts and brings a lot of hassles. If one gets sacked, one is less respected and runs more often into the problem of making ends meet. In this model, life-satisfaction follows the balance of turns to the good and the bad. In other words, life-satisfaction is predicted by the sum of changes in conditions that affect the daily flow of experiences. Because that balance changes over time, it is called the shift equilibrium model.

Theories that emphasize objective circumstances and shifting contextual sources as the most influential for life satisfaction judgments are commonly labeled as bottom-up theories. From this perspective, well-being is considered to be the accumulation of many small pleasures. In satisfaction term, this would mean that satisfaction with specific domains leads to satisfaction with life as a whole. An
example would be Sirgy’s (2000, 2001) bottom-up spillover in the field of economy. Another example can be found in the work by van Praag et al. (2003), who postulate a two-layer model where individual’s overall subjective well-being depends on different subjective domain satisfactions, which in turn, are considered to depend on objectively measurable variables, such as income.

(2) Top-Down Model

The second model adds to the first one by also taking into account that life-satisfaction is influenced not only by changes in life, but also or even more so by stable 'stocks' embodied in one's body, personality and social position. Such resources influence the course of events, for instance, the chance of being robbed in the street is lower for people in good mental health, and is also lower at the top of the social ladder than at the bottom. Some stocks also influence the affective impact of events. This model is called the 'stable component' model.

Casas (1996) assumes that there is a general global tendency to experience events in a positive way, so that satisfaction with life as a whole would influence satisfaction with specific life domains. In this same vein, Diener et al. (2000) consider that the differences between the two types of measure of satisfaction (global/abstract vs. specific/concrete.), can be used as indirect measures of the greater or lesser disposition of people to evaluate life in a positive way. Kozma et al. (2000) proposed propensity model, which defends the existence of a dispositional component which, acting as a personality trait, is responsible for the stability of psychological well-being despite changes in life circumstances. Top-down theories state that global personality traits predispose level of life satisfaction (Eid & Diener, 2004; and Heller et al., 2004).

Certain personality traits, in particular extraversion and neuroticism, determine to what degree people experience happiness (Costa & McCrae, 1980). Evidence of stability of life satisfaction (Diener et al., 1999) is assumed to support
the top-down perspective, indicating a strong association with stable personality traits and a weak influence of current mood, situational factors or long-term influence of life events (Suh et al., 1996; and Eid & Diener, 2004). Adaptation theory is one representative of the top-down perspective that provides a more complex elaboration of the finding that important life events such as changes in income, marital status, and health status only have short-term effects on life satisfaction.

There are also other models proposed to explain life satisfaction.

(i) **Bidirectional Model**

Drawing from Michalos’ (1995) Multiple Discrepancies Theory (MDT), it is argued that the two influences (bottom-up and top-down) take place simultaneously and, thus, relationships between satisfaction with life as a whole and with specific life domains are bidirectional. MDT represents satisfaction with life as a whole as the balance between the different sub-evaluations which are discrepancy judgments between perceptions of how life is and how it should be (Michalos, 1995). MDT has been, moreover, the basis for many studies on satisfaction (Cohen, 2000), although it has not been established that life satisfaction is determined in a causal way by the sub-evaluations of different aspects of life (Veenhoven, 1994), nor that sub-evaluations are caused by the levels of life satisfaction.

(ii) **Homeostatic Model of Well-Being**

Cummins (1998), Cummins & Cahill (2000), and Cummins & Nistico (2002) suggest the existence of a homeostatic control mechanism, which is assumed to control both overall subjective quality of life and the particular articulation of satisfaction with different life domains, evaluated through the personal well-being index (PWI). The psychological processing which is at its basis is considered to be a highly complex system which comprises both primary genetic capacities and a secondary protective system. The primary system provides a genetically
determined range of well-being perception, and includes personality traits and beliefs. If the influence of the outer environment is aversive enough, then the protective effect of the above mentioned determinants can be reduced, and so, well-being would have an inferior level.

(iii) **Hedonic Treadmill Theory**

Hedonic treadmill is a broad term for several theories, namely (a) habituation to repeatedly occurring events, (b) attention neglect of constant stimuli, and (c) sensitivity of the affect system to changes in one’s environment while being insensitive to constant stimuli (Diener et al., 2006; and Wilson & Gilbert, 2008).

It is important to note that hedonic treadmill theory is foremost a theory of affect and not a theory of cognitive evaluations of one’s life and life-satisfaction judgments. The theory describes two types of well-being.

(i) **Hedonic Well-Being** – Hedonic well-being is based on the notion that increased pleasure and decreased pain lead to happiness. Hedonic concepts are based on the notion of subjective well-being. Subjective well-being is a scientific term that is commonly used to denote the “happy or good life”. It comprises of an affective component (higher positive affect and lower negative affect) and a cognitive component (satisfaction with life). It is proposed that an individual experiences happiness when positive affect and satisfaction with life are both high (Carruthers & Hood, 2004).

(ii) **Eudaimonic Well-Being** – Eudaimonic well-being on the other hand, is strongly reliant on Maslow’s (1954) ideas of self-actualization and Roger’s (1999) concept of the fully functioning person and their subjective well-being. Eudaimonic happiness is therefore based on the premise that people feel happy if they experience life purpose, challenges and growth. This
approach adopts ‘Self-Determination Theory’ to conceptualize happiness (Deci & Ryan, 2000; and Keyes et al., 2002). Self-determination theory suggests that happiness is related to fulfillment in the areas of autonomy and competence. From this perspective, by engaging in eudaimonic pursuits, subjective well-being (happiness) will occur as a byproduct. Thus, life purpose and higher order meaning are believed to produce happiness.

It appears that the general consensus is that happiness does not result from the pursuit of pleasure but from the development of individual strengths and virtues which ties in with the concept of positive psychology (Vella-Brodrick et al., 2009).

(iv) **Aspiration Spiral Theory**

An alternative explanation for adaptation effects in Life-satisfaction judgments is aspiration spiral theory (Stutzer, 2004; Dolan & White, 2007; and Diener et al., 2009). Accordingly, people’s aspirations change in response to changes in their life circumstances. For example, judgments of satisfactory or ideal income are strongly influenced by actual income (Stutzer, 2004). Life-satisfaction judgments would reflect what people do not have rather than what they actually have, and because people’s aspirations are grounded in their life circumstances. Life-satisfaction judgments are insensitive to actual differences in life circumstances.

**DOMAINS OF LIFE SATISFACTION**

The domains-of-life literature states that life can be approached "as a general construct of many specific domains, and that life satisfaction can be understood as the result of satisfaction in the domains of life (Headey et al., 1984; Headey & Wearing, 1992; Meadow et al., 1992; Sirgy et al., 1995; Cummins, 1996, 1998, 2003; Saris & Ferligoj, 1996; Veenhoven, 1996; Rampichini & D'Andrea, 1998; and Salvatore & Munoz, 2001). Consequently, a relationship between life satisfaction and satisfaction in domains of life is assumed."
Flanagan (1978) mentioned 15 components, which are economic, physical, and health well-being, having and raising children, relations with spouse, with relatives and with friends, community and social activities, political activities, passive and active recreational activities, personal development activities, and work. Headey & Wearing (1992) used leisure, marriage, work, standard of living, friendships, sex life, and health domains. On the basis of a meta-study of the literature Cummins (1996) had argued for a seven-domain partition: material well-being, health, productivity, intimacy, safety, community, and emotional well-being. Argyle (2001) mentions domains such as money, health, work and employment, social relationships, leisure, housing, and education.

A few investigations have studied satisfaction in all domains of life (Haavio-Mannila, 1971; Andrews & Whitney, 1976; Campbell et al., 1976; Campbell, 1981; and Zapf & Glatzer, 1987). However, most researchers have focused on the study of satisfaction in a few or just one domain of life; for example, job-satisfaction studies. The relationship between subjective well-being and a person's condition in a few domains is also the main research topic of many studies; for example, employment and happiness (Clark & Oswald, 1994; and Di Tela et al., 2001).

van Praag et al. (2003) studied the relationship of satisfaction in different domains of life (health, financial situation, job, housing, leisure, and environment) and satisfaction with life as a whole. They state that "satisfaction with life as a whole can be seen as an aggregate concept, which can be unfolded into its domain components".

Life satisfaction, considered a cognitive, judgmental process may be defined as "a global assessment of a person's quality of life according to one's chosen criteria" (Shin & Johnson, 1978). In-other words, people judge or evaluate how content they are with their general circumstances by comparing it to a standard that they deem appropriate for themselves. Furthermore, life satisfaction is not unidimensional i.e.,
when assessing life satisfaction, individuals' overall perception of life or their satisfaction with life as a whole must be considered (Diener et al., 1985). Based on the findings of a longitudinal study, Headey & Wearing (1989) concluded that individuals have a 'set-point' for their subjective well-being or SWL. While the level of life satisfaction could be negatively affected by certain life events, this appeared to be temporary; over time, the participants reverted to their original base-line level of life satisfaction. Satisfaction with life (SWL), a cognitive, global evaluation of one's life satisfaction, is an important aspect of psychological health and a key dimension of subjective well-being (Diener, 1984; and Pavot & Diener, 2008). SWL also uniquely predicts other important outcomes over varied time periods and in many populations, including self-reported physical health over time (Hirdes & Forbes, 1993), and reduced mortality or increased longevity among British (Bowling & Grundy, 2009), Taiwanese (Mete, 2005), Dutch (Deeg & van Zonneveld, 1989), and among Swedish (Parker et al., 1992) elderly as well as elderly twins (Lyyra et al., 2006). The ability of SWL to predict lower risk of mortality is robust, occurring among healthy persons and persons with diseases (Chida & Steptoe, 2008) as well as both younger (below age 55) and older (above age 55) persons (Xu & Roberts, 2010). Cummins & Nistico (2002) observed that a considerable majority of people seem to be satisfied with their lives and most people experience a level of satisfaction with their life that is moderately positive. One reason, among many, that have been suggested for the observed homeostatic or persistence in the level of life satisfaction is that most people have positive feelings of self-worth, perceived control, and optimism.

In a study of a German population, Fujita & Diener (2005) found, that there was a significant decline in life satisfaction over time. Gerstorf et al. (2008) found that the decline in life satisfaction was related to the distance to death. However, a study on a Finnish population showed that the life satisfaction was relatively stable and only decreased slightly over 15 years. Old women had lower subjective well-being than men (Pinquart & Sorensen, 2001; and Carmel & Bernstein, 2003).
DETERMINANTS OF LIFE-SATISFACTION

At every period of life-span, life satisfaction is influenced by a number of factors. Good physical and mental health, physical attractiveness, degree of autonomy, interactional opportunities outside the family, type of work, work status, living conditions, emotional adjustment, inability to experience and verbalize emotions (alexithymia), personality disorder, marital status and gender etc. are a few to count in this regard.

Bramson et al. (2002) assert that life satisfaction is related with a wide range of factors. These factors were modeled in three levels such as individual-based variables like personality traits; cognitive variables like control, self-esteem and optimism, and socio-environmental factors.

It is necessary to identify those factors that contribute to satisfaction in each domain of life. There is evidence that physical activity is positively related to life satisfaction (McAuley et al., 2000; Rejeski & Mihalko, 2001; and Elavsky & McAuley, 2005). Moreover, Decker & Schultz (1985) have found that healthy persons have greater life satisfaction than patients with particular health problems.

According to Antonucci et al. (2001) interacting with others seems to make people more integrated in society i.e., more connected to family, friends, and community. This social connectedness and integration improves one’s health mentally as well as physically. This statement is in line with Böhnke (2005) who found that for Europeans in general, family is the most reliable form of support they can depend upon if help is needed. Friends also provide important support, but only a minority of people can count on neighbors or work colleagues if they are in need. Böhnke (2005) found that in relatively affluent countries, social support influences life satisfaction more than in countries where the standard of living is generally low and people have to cope with poor living conditions.
Numerous studies concluded that good and close relationships with other people—partners and spouses, parents and children, kinsmen, friends, neighbours and workmates— are a major source of life satisfaction (Haller & Hadler, 2006).

ALEXITHYMIA AND LIFE SATISFACTION

In the early 1970s, Sifneos (1973) coined the term “alexithymia” which means “no words for feelings”, and it refers to a personality construct characterized by impoverishment of fantasy, poor capacity for symbolic thought and an inability to experience and verbalize emotions. It is, by definition, considered a stable personality trait (Sifneos, 1973; and Taylor, 2000).

Alexithymia is considered to be a personality trait that places individuals at risk for other medical and psychiatric disorders while reducing the likelihood that these individuals will respond to conventional treatments for the other conditions. Unlike the form of autism known as Asperger’s syndrome, alexithymia is not a disorder classified in the DSM-IV. Rather, alexithymia is a personality trait (Sifneos, 1973; and Taylor, 2000) that puts people at risk for medical and psychological disorders and makes individuals less likely to respond to treatment for them.

Alexithymia is defined by

1. difficulty in identifying feelings and distinguishing between feelings and the bodily sensations of emotional arousal,
2. difficulty in describing feelings to other people,
3. constricted imaginal processes, as evidenced by a scarcity of fantasies, and
4. a stimulus-bound, externally oriented cognitive style.

In studies of the general population the degree of alexithymia was found to be influenced by age, but not by gender; the rates of alexithymia in healthy controls have been found at: 8.3% (2 of 24 persons) 4.7% (2 of 43); 8.9% (16 of 179); and 7%
The prevalence of alexithymia in working-age population has been shown to be about, 9%-17% for men, and 5%-10% for women (Lane et al., 1998; Salminen et al., 1999, Honkalampi et al., 2000; and Kokkonen et al., 2001). A less common finding suggests that there may be a higher prevalence of alexithymia amongst males than females, which may be accounted for by difficulties some males have with "describing feelings", but not by difficulties in "identifying feelings" in which males and females show similar abilities.

The alexithymia construct is strongly inversely related to the concepts of psychological mindedness and emotional intelligence. Bagby et al. (1994) state that there is "strong empirical support for alexithymia being a stable personality trait rather than just a consequence of psychological distress". Other opinions differ and can show evidence that it may be state-dependent. Bagby et al. (1994) also suggest that there may be two kinds of alexithymia, "primary alexithymia" which is an enduring psychological trait that does not alter over time, and "secondary alexithymia" which is state-dependent and disappears after the evoking stressful situation has changed. These two manifestations of alexithymia are otherwise called "trait" or "state" alexithymia.

Typical deficiencies may include problems in identifying, describing, and working with one's own feelings, often marked by a lack of understanding of the feelings of others; difficulty in distinguishing between feelings and the bodily sensations of emotional arousal; confusion of physical sensations often associated with emotions; few dreams or fantasies due to restricted imagination; and concrete, realistic, logical thinking, often to the exclusion of emotional responses to problems. Those who have alexithymia also report very logical and realistic dreams, such as going to the store or eating a meal. Clinical experience suggests that it is the structural features of dreams more than the ability to recall them that best characterizes alexithymia.
Some alexithymic individuals may appear to contradict the above mentioned characteristics because they can experience chronic dysphoria or manifest outbursts of crying or rage. However, questioning usually reveals that they are quite incapable of describing their feelings or appear confused by questions inquiring about specifics of feelings.

According to Krystal (1979), individuals suffering from alexithymia think in an operative way and may appear to be super-adjusted to reality. In psychotherapy, however, a cognitive disturbance becomes apparent as patients tend to recount trivial, chronologically ordered actions, reactions, and events of daily life with monotonous detail. In general, these individuals lack imagination, intuition, empathy, and drive-fulfillment fantasy, especially in relation to objects; instead, they seem oriented toward things and even treat themselves as robots. These problems seriously limit their responsiveness to psychoanalytic psychotherapy. Psychosomatic illness or substance abuse is frequently exacerbated should these individuals enter psychotherapy.

Even before coining the term, Sifneos (1967) noted patients often mentioned things like anxiety or depression. The distinguishing factor was their inability to elaborate beyond a few limited adjectives such as "happy" or "unhappy" when describing these feelings. The core issue is that alexithymics have poorly differentiated emotions limiting their ability to distinguish and describe them to others. This contributes to the sense of emotional detachment from themselves and difficulty connecting with others, making alexithymia negatively associated with life satisfaction even when depression and other confounding factors are controlled for.

It is unclear what causes alexithymia, though several theories have been proposed. There is evidence both for a genetic basis, meaning some people are predisposed to develop alexithymia, as well as for environmental causes.
Early studies showed evidence that there may be an inter-hemispheric transfer deficit among alexithymics; that is, the emotional information from the right hemisphere is not being properly transferred to the language regions in the left hemisphere, be caused by a decreased corpus callosum, often present in psychiatric patients who have suffered severe childhood abuse. Neuropsychological evidences indicate that alexithymia may be due to a disturbance to the right hemisphere of the brain, which is largely responsible for processing emotions. In addition, another neuropsychological evidence suggests that alexithymia may be "elated to a dysfunction of the anterior cingulate cortex. McDougall (1985) objected to the strong focus by clinicians on neurophysiological at the expense of psychological explanations for the genesis and operation of alexithymia. He introduced the alternative term "disaffection" to stand for psychogenic alexithymia. For McDougall (1985), the disaffected individual had at some point "experienced overwhelming emotion that threatened to attack their sense of integrity and identity", to which they applied psychological defenses to pulverize and eject all emotional representations from consciousness.

McDougall (1985) noted that all infants are born with inability to identify, organize, and speak about their emotional experiences (the word ‘infansis’ from the Latin "not speaking"), and are by reason of their immaturity inevitably alexithymic. Based on this fact McDougall (1985) proposed that the alexithymic part of an adult personality could be "an extremely arrested and infantile psychic structure". The first language of an infant is nonverbal facial expressions. The mother's emotional state is important for determining how any child might develop. Neglect or indifference to varying changes in a child's facial expressions without proper feedback can promote an invalidation of the facial expressions manifested by the child. The parent’s ability to reflect self-awareness to the child is another important factor. If the adult is incapable of recognizing and distinguishing emotional expressions in the child, it can influence the child’s capacity to understand emotional expressions.
Although environmental, neurological, and genetic factors are each involved, the role of genetic and environmental factors for developing alexithymia is still unclear. The results from a large population-based sample of Danish twins (Jorgensen et al., 2007) suggest that genetic factors have a noticeable and similar impact on all facets of alexithymia. While the results suggested a moderate influence of shared environmental factors, results are in concordance with the general finding that environmental influences on most psychological traits are primarily of the nonshared rather than the shared type. One hypothesized environmental cause is head injury; persons suffering a traumatic brain injury are six times more likely to exhibit alexithymia.

Study by Posse & Hallstorm (1999) aimed at to describe how the scores of the test designed to measure alexithymia were distributed in the primary care outpatient population. They also wanted to examine the relationship of alexithymia to socio-demographic variables and personality traits. 450 consecutive patients at the Primary Health Care Centre were asked to voluntarily complete an inventory consisting of several scales designed to test alexithymia and somatisation as well as general personality traits. The prevalence of alexithymia as measured using the Schalling Sifneos Personality Scale (SSPS) was 20.0% (men 28%, women 12%). Alexithymia was significantly associated with higher age, having a lower educational background, living alone but having more children. The personality traits associated with SSPS scores were Suspicion and Distance. High grade SSPS scores were also associated with high scores on somatic anxiety, psychastenia, and irritability and with low scores for socialisation (p<0.01). The conclusions reached regarding prevalence rate, age, sex and education are consistent with other findings. When data were analyzed as continuous variables, high grade scores for alexithymia became significantly associated with somatic anxiety, psychastenia, irritability as well as low grade reliability to socialize.
Chaotic interpersonal relations had also been observed by Sifneos (1973). Due to the inherent difficulties in identifying and describing emotional states in self and others, alexithymia also negatively affected relationship satisfaction between couples.

Inadequate "differentiation" between self and others by alexithymic individuals has been observed by Taylor et al. (1997), and Blaustein & Tuber (1998). According to Vanheule et al. (2006) alexithymia creates interpersonal problems because these individuals avoid emotionally close relationships, or if they do form relationships with others they tend to position themselves as either dependent, dominant, or impersonal, "such that the relationship remains superficial".

In a study (Vanheule et al., 2007), a large group of alexithymic individuals completed the 64-item Inventory of Interpersonal Problems (IIP-64) which found that "two interpersonal problems were significantly and stably related to alexithymia: cold/distant and non-assertive social functioning. All other IIP-64 subscales were not significantly related to alexithymia.

Several variables including hope and positive affect (Kortte et al., 2010), grit or perseverance (Singh & Jha, 2008), facets of emotional intelligence (ability to repair negative moods and maintain positive moods (Thompson et al., 2007), and perceived ability to understand and discriminate between moods and emotions (Palmer et al., 2002), optimism (Daukantaite & Bergman, 2005), and both optimism and pessimism (Libran & Piera, 2008) have been found to predict SWL above the variance accounted for by negative affect. However, only one of these studies tested the ability of predictors to moderate the negative affect-SWL relationship, and this study found no significant moderation (Thompson et al., 2007).

Social-cognitive variables – particularly self-efficacy beliefs about ability to regulate negative affect (SERN) – may be particularly important to SWL and in theory may also moderate the negative affect – SWL relationship. Moreover,
subtypes of SERN also have been found to predict unique variance in SWL and, in a cross-sectional study, to moderate the negative affect – SWL relationship.

Health and well-being are best predicted by factor 1 of the alexithymia construct: difficulty in identifying emotions is indeed negatively related to those variables. Partial correlational analyses found that total scores on the TAS were significantly and negatively correlated with scores on satisfaction with life abroad \( (r = -0.342, p<.05) \), and significantly and positively correlated with scores on satisfaction with life in home country prior to departure. Two alexithymia variables, difficulty in identifying feelings, and externally oriented thinking, were found to be significant predictors of satisfaction with life in home country (Fukunishi et al., 1999).

Honkalampi et al. (1999) studied the factors associated with alexithymia in 137 depressed outpatients. Diagnosis of depression was confirmed by means of the Structured Clinical Interview for DSM-III-R. Alexithymia was screened using the 20-item version of the Toronto Alexithymia Scale. Severity of depression was assessed using the 21-item Beck Depression Inventory, and other psychiatric symptoms with the help of the Symptoms Checklist (SCL-90). Life satisfaction was also assessed with a structured scale. It was found that almost half of the patients were alexithymic. They were significantly more often male, unmarried and had a lower education than the nonalexithymic patients. Alexithymic patients more often showed psychiatric symptoms (SCL-90) and were also more often severely depressed and dissatisfied with their life than were the other patients.

Valkamo et al. (2001b) studied about alexithymia in patients with coronary heart disease. The aim of this study was to investigate factors associated with alexithymia. Logistic regression analysis revealed that the factors independently associated with alexithymia were currently or previously being a blue-collar worker (adjusted odds ratio, AOR: 4.8), self-rated depression (AOR: 3.2), and dissatisfaction with life (AOR: 2.9).
The purpose of the research (Schmitz et al., 1999) was to investigate the effects of alexithymia on life satisfaction. Results of a structural equation model indicated that nonalexithymic individuals were more self-nurturant than those with alexithymia. Those students who were more self-nurturant, and who used positive strategies to regulate painful emotions, also reported higher levels of life satisfaction. Individuals with alexithymia reportedly used more negative strategies to modulate affect and were also less satisfied with life. The indirect path between alexithymia and satisfaction with life was mediated by self-nurturance and by negative affect regulation. Thus, individuals with alexithymia reported less life satisfaction than other participants due to their more frequent use of negative affect regulation strategies and inability to self-nurture.

Lane et al. (2000) found that high alexithymic subjects were consistently less accurate in emotion recognition. Swart et al. (2009) observed that high alexithymic individuals used more impressive and less reappraisal strategies. On the behavioural tasks, as expected, high alexithymics performed worse on recognition of micro expressions and emotional mentalizing.

Alexithymia is a risk factor for life dissatisfaction in primary care patients. Alexithymia has been shown to be associated with several medical conditions and mental health problems, including depression leading to life dissatisfaction (Taylor, 2000; and Taylor & Bagby, 2004).

An association between alexithymia and dissatisfaction has been observed in finish population studies (Honkalampi et al., 2000, 2004), two studies on coronary heart disease patients (Valkamo et al., 2001a, 2001b), and in a study of outpatients with depression (Honkalampi et al., 1999).

Le et al. (2002) conducted a cross-cultural study and found that life satisfaction was negatively correlated with alexithymia in American students.
Mattila et al. (2007) studied the relationship between life satisfaction and alexithymia in a sample of 229 patients as a part of a naturalistic follow-up study of depression in Finish primary health care. The measures were the abbreviated Life Satisfaction Scale and the 20-item Toronto Alexithymia Scale. Depression was assessed with the help of short form of the Composite International Diagnostic Interview held telephonically. Of all subjects, 19.2% were alexithymic, and 9.2% were depressed. Alexithymia was negatively associated with life satisfaction even when depression and other confounding factors were controlled for.

In a 2008 (Hesse & Floyd, 2008) study, alexithymia was found to be correlated with impaired understanding and demonstration of relational affection, and that this impairment contributed to poorer mental health, poorer relational well-being, and lowered relationship quality.

**BORDERLINE PERSONALITY DISORDER AND LIFE SATISFACTION**

Within the clinical psychology, the Borderline Personality Disorder (BPD) remains a very difficult disorder to be diagnosed. Not only do patients with BPD often show differential diagnoses and comorbidity with other personality disorders, the term BPD has also long been interpreted as a negative term among most clients meeting the diagnostic criteria (Krawitz, 2004). The name BPD refers to the belief that patients meeting the criteria were on the border between psychosis and neurosis, although many clinicians find the term BPD lacking in validity and reliability, it has been found its way into the DSM-IV as a disorder of the B-cluster. Meijer (1998) states that "the term borderline refers 'to a group of disorders which in terms of the nature and severity of their symptoms occupy a position between neuroses and psychoses".

The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV, American Psychiatric Association, 1994) describes borderline personality disorder (BPD) as a ‘pervasive pattern of instability of interpersonal relationships, self-image,
and affects, and marked impulsivity beginning by early childhood and present in a variety of contexts’ (p. 654). Specific problems include frantic efforts to avoid real or imagined abandonment, identity disturbance, para-suicidal or suicidal behaviour, chronic feelings of emptiness, transient stress related paranoid ideation and severe dissociate symptoms. In an attempt to understand BPD, Linehan (1993) organized the DSM-IV diagnostic criteria into five areas of dysregulation: emotional, cognitive, behavioural, self, and interpersonal. Linehan (1993) positioned emotional dysregulation central to BPD, with cognitive, behavioural, self, and interpersonal dysregulation occurring either as consequence of emotional dysregulation or as maladaptive attempts to regulate problematic emotions. Emotional dysregulation is a consequence of high emotional reactivity, strong experienced emotional intensity and a lack of skills for managing strong emotions.

It is estimated that borderline personality disorder is to occur in 2% of the general population and thereby BPD belongs to one of the most common personality disorders in clinical settings (Scodol et al., 2002). Borderline personality disorder has always been affiliated with other personality problems, e.g., alcohol and substance abuse, suicidal tendency, auto mutilation and sexual abuse. Krawitz (2004) found that as many as 90% of the patients meeting the criteria to be diagnosed with BPD have a frequent history of trauma. BPD was initially conceptualized as a mild form of schizophrenia, later as an affective disorder, and more recently as a variant of a traumatic stress disorder (Golier et al., 2003).

In the clinical field of psychiatry, the term BPD has existed for a long time, and has been used to indicate a serious pathology of doubtful diagnostic affiliation (Hartocollis, 1977). Goldstein (1985) compares the impulsive personality of borderline with the ego and id from Freud (1940), telling that the mind is split up in three forms of personality; ego, id, and superego. The impulsive personality would be easily in the id, whereas the ego would be the mind, controlling the overall behaviour and sense making in thought processes. Larsen & Buss (2005) explain
that patients with a BPD are marked by instability, not only in their behaviour, but in their relationships also. The relationships are mostly intense, emotional, and potentially violent. Borderline patients suffer from strong fears of abandonment. When borderline patients feel the fear of losing a relationship, their self-image and behaviour change rapidly which has devastating results for the relationship. Their attitude can change from friendly and dependent to very angry and aggressive. When the relationships are failing apart, the borderline patient often tries to manipulate the other person by self-mutilating behaviour or suicide attempts. Larsen & Buss (2005) also argue that borderline patients have "shifting "views of themselves. Their values and norms can change easily as their opinions and sexual orientations. In most cases they look at themselves as "evil" or “bad". Another common characteristic in borderline personality disorder is the tendency to have strong emotions, including panic, anger and despair. Both of them are caused by interpersonal events, especially abandonment or neglect. Under stress, borderline patients may have periods in which they become bitter, sarcastic or aggressive which are then followed by shame, guilt, feelings of being bad and empty. In a study among hospital patients (n = 84), 72.6 % had a history of such activities (Soloff et al., 1994). In this experiment they also found a correlation between self-harming and the threat of others to leave or demand the borderline person.

The borderline personality disorder is characterized by a pervasive pattern of impulsivity and instability, along with self-damaging behaviour, both physical (automutilation and suicidal behaviour) and psychological (binge-eating, unsafe sex, gambling). The identity of borderline patients shows distress or impairment in social-occupational, interpersonal or other important functioning. The proportions of friendship e.g., are exaggerated by idealization. Borderline patient may have a pattern of undermining themselves when an important goal has to be achieved or realized, along with chronic feelings of emptiness and intense anger. The development of psychotic-like symptoms in times of stress is also likely to exist.
among borderline patients (APA, 2000). Another terms often used in the classification of BPD are: low level borderline, intermediary level borderline, and high level borderline (Derksen et al., 1998).

Low level Borderline is found in different patients i.e., (1) patients with structural and descriptive patients, who have a lot of the symptoms in the form of severe fear and mood- and/or sexual disorders, (2) subtype patients according to the cluster A features and perhaps narcissistic and antisocial traits, (3) patients with lacking intelligence and introspection, self-damaging behaviour and insufficient social adoption, (4) patients with reduced or unpresent social support, and (5) patients with few to none motivation to change.

The intermediary borderline patients meet the descriptive and structural borderline criteria, have a lot of symptom-disorders, show traits of the B cluster, have a lot of impulsivity with lacking social support and here the motivation is also limited.

The high level borderline patients often answer only to the structural criteria and, in moments of extreme overburdening, the descriptive pattern is visible. The comorbidity is limited to the cluster C and the impulsivity, social support and suicidal behaviour are often present and shown only in periods of stress. Furthermore, they have enough motivation to change (Derksen et al., 1998).

Studies suggest that individuals with BPD tend to experience frequent strong and long lasting states of aversive tension often triggered by perceived rejection, being alone or perceived failure. Individuals with BPD may show liability between anger and anxiety or between depression and anxiety and temperamental sensitivity to emotive stimuli. The negative emotional states particularly associated with BPD have been grouped into four categories: extreme feelings in general; feelings of destructiveness or self-destructiveness; feelings of fragmentation or lack of identity; and feelings of victimization.
Individuals with BPD can be very sensitive to the way others treat them, reacting strongly to perceived criticism or hurtfulness. Their feelings about others often shift from positive to negative, generally after a disappointment or perceived threat of losing someone. Self-image can also change rapidly from extremely positive to extremely negative. Impulsive behaviours are common, including alcohol or drug abuse, unsafe sex, gambling and recklessness in general attachment. Studies suggest individuals with BPD, while being high in intimacy- or novelty-seeking, can be hyper-alert to signs of rejection or not being valued and tend toward insecure, avoidant or ambivalent, or fearfully preoccupied patterns in relationships. They tend to view the world generally as dangerous and malevolent and themselves as powerless, vulnerable, unacceptable and unsure in self-identity.

Parents of individuals with BPD have been reported to show co-existing extremes of over-involvement and under-involvement. BPD has been linked to increased levels of chronic stress and conflict in romantic relationships, decreased satisfaction of romantic partners, abuse and unwanted pregnancy; these links may largely be general to personality disorder and sub-syndromal problems, but such issues are commonly raised in support groups and published literature for partners of individual with BPD. Suicidal or self-harming behaviour is one of the core diagnostic criteria of DSM IV-TR. Management of and recovery from this can be complex and challenging.

The suicide rate is approximately 8 to 10 percent in BPD patients. Self-injury attempts are highly common among patients and may or may not be carried out with suicidal intent. BPD is often characterized by multiple slow-lethality suicide attempts triggered by seemingly minor incidents, and less commonly by high-lethality attempts that are attributed to impulsiveness or comorbid major depression, with interpersonal stressors appearing to be particularly common triggers. Ongoing family interactions and associated vulnerabilities can lead to self-destructive behaviour. Stressful life events to sexual abuse have been found to be a particular trigger for suicide attempts by adolescents with a BPD diagnosis.
Two constructs that have been associated with how individuals regulate their emotions are emotional intelligence and alexithymia. The relationship between alexithymia and BPD suggests that difficulty in identifying, differentiating, understanding, and communicating emotions and feelings (somatic sensations) impairs ability of a person to regulate emotions and remains dissatisfied with life as the consequence. Web & McMurran (2008) observed alexithymia significantly predicted borderline personality disorder traits.

In a two-year-long study (Trull et al., 1997), BPD traits were revealed to be associated with problematic mood patterns of uncontrollable anger and affective liability. People with features of BPD were more likely to meet lifetime criteria for mood disorder and experienced greater interpersonal dysfunction than their peers. These findings indicated that features of BPD were associated with poorer outcomes even with nonclinical populations, which highlighted the need to detect emotional dysfunction in those with features of BPD in order to prevent longer term negative outcomes and life dissatisfaction.

Although many studies in neurophysiological functioning show variability in outcomes, many scientists believe BPD is caused by neurological dysfunction. In their research Sprock et al. (2000) compared a group of borderline patients with two control groups; the first existed out of patients with a depressive disorder, because they believed depressive patients were uncontrol group due to the frequent co-occurrence of depression with BPD. The second control group existed out of individuals without a history of mental disorder. Both of the individuals were administered two structured interviews for: first, the diagnosis of mental disorders and second, health questionnaires to screen for substance use along with psychotic, neurological or sensory disorders that could affect their functioning. In the first of their study they used like the Stroop Color-Word Test, the Porteus Mazes, the Trail-Making Test, CES-D, WAIS-R and Demographic/Health Questionnaires. The depressive patients together with the borderline patients used significantly longer
time than the nonclinical group to complete the task. Sprock et al. (2000) noted that the depressed patients were significantly slower than the normal group for Trails Stroop Condition 3 and also made more errors than both other groups on Stroop Condition 3 (words were the names of colors and examinees needed to name the ink color and ignore the content of the word, which was the name of another colour). In part II of their study they administered tests as part of the overall cognitive battery. Near the end emotional conditions were administered to avoid carry-over effects. They found that the use of emotional interference in word-recall did not affect the performance of the BPD or the other groups, BPD patients also or did recall fewer emotional story themes than the normal group. On the contrary, depressives did recall fewer positive words than the two other groups, they outperformed in recall of neutral and negative (delayed recall) words as well (Sprock et al., 2000). According to the study of Philipsen et al. (2008), there is an overlap in neurological mechanisms between individuals with the Attention Deficit Hyperactive Disorder (ADHD) and patients with BPD. In her study, Philipsen et al. (2008) found some evidence for a dopamioergic dysfunction in BPD. Because ADHD and BPD are both characterized by impulsive behaviour, the serotonergic and noradrenergic systems are involved in impulsivity and aggression. Borderline patients who received serotonin reuptake inhibitors (SSRI) noticed a reduction in their impulsivity. Recently, Reitz et al. (2004) reported findings of a potential serotonergic dysfunction in ADHD (Philipsen et al., 2008). He also noticed that there was evidence for a noradrenergic dysfunction in ADHD and BPD. Schmahl & Bremner (2006) found the results of structural imaging studies to be consistent with smaller hippocampus as well as amygdala volumes in adult patients with BPD. Work in animals has shown that the amygdala has a central role in emotional regulation (Lieb et al., 2004). Lieb et al. (2004) also observed that reduced hippocampus volume was consistent with many studies in Post Traumatic Stress Disorder (PTSD). Through structured and functional neuroimaging, dysfunctional network of brain regions has been revealed that seems to mediate the major part of the BPD
symptomatology. The frontolimbic network consists of the anterior cingulate cortex (ACC), the orbitofrontal and dorsolateral aiprefrental cortex, hippocampus and amygdala, together with altered baseline metabolism, in prefrontal regions including the anterior cingulate cortex (Schmahl & Bremner, 2006). According to these scientists, these brains also seem to be involved in dysfunctional serotonergic neurotransmission, which has been associated with disinhibited impulsive aggression in patients with BPD. Schmahl & Bremner (2006) believed that deactivation or failure of activation of the AGO in patients with BPD had shown consistency with challenging studies using emotional, stressful and sensory stimuli. Concluding that the AGO may be viewed as a brain region mediating affective-control and dysfunction in this, could be related to affective dysregulation which is characteristic of BPD. The most consistent finding has been a reduction in metabolic activity in the frontal region, particularly the medial frontal area, parts of the cingulate, the subgenual prefrontal cortex, and the dorsolateral prefrontal cortex (Koenigsberg et al., 1985). The studies/reviews of Schmahl & Bremner (2006) and Sprock et al. (2000) have shown the interesting fact that the anterior cingulate cortex or ACC is a neurological key-element in the dysregulation of affection and attention in a borderline personality disorder, whereas, Sprock et al. (2000) concluded that there was little evidence of frontal or temporal lobe dysfunction in patients with BPD. At first sight, this seems a contradiction. But in the study of Sprock et al. (2000) the borderline patients showed remarkable significant difference in the second conditions of the Stroop Color-Word Test; the patients reacted slower and made more errors. According to Kolb & Whishaw (2003) the ACC and the prefrontal areas show activation during visual tasks and attention along with the occipital temporal cortex, which is activated for attention to features such as colour and form. When specific sensory modality, such as vision or touch, is activated, a specific sensory area in the brain responds. This area is called the anterior cingulate cortex. The fact that the borderline and depressed patients took significant more time to complete the Stroop test, tells that there is a possible lack
of attention. The brain area is co-responsible for attention, and thus possibly responsible for the loss of attention and focus in a borderline personality disorder.

Leible & Snell (2004) found that BPD was positively associated with private emotional attention, private emotional preoccupation and rumination, and public emotion monitoring. They also found that BPD participants experienced emotional clarity and repair. These findings suggest that those diagnosed as BPD report a poor understanding of the nature of their emotions and a reduced capacity to overcome negative emotional experiences, which constitutes a reduced level of emotional intelligence and leads to life dissatisfaction.

MARITAL STATUS AND LIFE SATISFACTION

More than 9 in 10 people worldwide eventually get married (Myers, 2000) and an even greater percentage is in committed intimate relationships. Surveys show that married people are happier than those who are single, divorced, or widowed (Diener et al., 1999). For example, in a study of 19 countries, Mastekassa (1994) found that married people were happier than all the other groups. Numerous studies with respondents from diverse cultures support this finding (Glenn & Weaver, 1979; Kozma & Stones, 1983; Lee et al., 1991; Stack & Eshleman, 1998; Marks & Fleming, 1999; and Diener et al., 2000; and Tsou & Liu, 2001). With marriage people engage in a long term relationship with a strong commitment to a mutually rewarding exchange. The spouse expects some benefits from the partner’s expressed love, gratitude and recognition, as well as from security and material rewards.

Ball (1983) studied the relationships between marital status, household structure, and life satisfaction in a probability sample of 373 black women. He found that married, widowed, and divorced women had the highest life satisfaction. Single and separated women were less satisfied, although this may be related to other variables, such as age. Having children did not significantly affect satisfaction, nor, for women without husbands, did residing with relatives or friends.
Ball & Robbins (1986) studied the relationship between marital status and overall life satisfaction among black Americans on a probability sample of 373 black women and 253 black men. For women, it was found that the married, widowed, and divorced were more satisfied with their lives than were the separated or single. However, when controls for age, social participation, health, adjusted income, and education were introduced, these differences no longer were statistically significant. For men, the married were the least satisfied persons of any category. When the controls were added, married men were found significantly less satisfied than divorced, separated, and widowed.

Economists have in particular, studied the financial benefits of marriage. Marriage provides basic insurance against adverse life events and allows gains from economies of scale and specialization within the family (Becker, 1981). With specialization, one of the spouses has advantageous conditions for human capital accumulation in tasks demanded on the labor market. It is reflected in married people earning higher incomes than single people ceteris paribus (Chun & Lee, 2001; and Stutzer & Frey, 2003). The benefits from marriage go beyond increased earnings. These benefits have been studied in psychology, sociology, and epidemiology. Researchers in these fields have documented that, compared to single people, married people have better physical and psychological health (e.g., less substance abuse and less depression) and that they live longer (Burman & Margolin, 1992; and Waite & Gallagher, 2000). Recently there has been an increasing interest in the effect of marriage on people’s happiness. It has been found that marriage goes hand in hand with higher happiness goal in a large number of studies covering different countries and time periods (Stack & Eshleman, 1998; and Diener et al., 2000). Married persons report greater subjective well-being than persons who have never been married or have been divorced, separated or widowed. The major sources of increased well-being in marriage are directly tested with data on reported satisfaction with life. Coyne & DeLongis (1986) found that the marital relationship protects partners from the negative effects of stress.
Diener et al. (2000), based on prior literature, concluded that married individuals consistently reported greater subjective well-being than previously married individuals (i.e., divorced, separated, or widowed). A possible reason for these findings is provided by Shapiro & Keyes (2008), who say that marriage represents a social contract that bonds individuals together in an intimate relationship that can be stress-buffering and socially integrative. They also maintain that a substantial body of research indicates that married individuals do not only have additional mental benefits over their non-married counterparts, but also sizeable physical advantages.

Holt-Lunstad et al. (2008) found that both marital status and marital quality were important. Married individuals had greater life satisfaction with life (SWL) and blood pressure dipping than single individuals. Finding indicates being married per se is not universally beneficial, rather, the satisfaction and support associated with such a relationship is important. However, marriage may be distinctive, as evidence further suggests that support from one’s network does not compensate for the effect of being single. These results highlight the complexities in understanding the influence of social relationships on long-term health, and they may help clarify the physiological pathways by which such associations exist.

Taylor et al. (2011) contributes to the literature by focusing on two groups of unmarried persons – those who are cohabiting and persons who are unmarried/non-cohabiting – in addition to married persons. Findings indicate that emotional support from extended family is positively associated with relationship satisfaction for married and cohabiting African Americans and Black Caribbeans who are romantically involved. Negative interaction from extended family is associated with lower relationship satisfaction for married, cohabiting, and romantically involved African Americans and for married Black Caribbeans.

The literature on the effect of marriage on well-being is twofold. One body of research has explored the effect of marital status (married vs. unmarried) on
indicators of individual well-being, including manifestations of physical and mental illness as well as subjective well-being. Another body of research has examined marital quality as a predictor of individual well-being based on a similar set of indicators. Researches has found that married people, on average, are happier than unmarried people (Frey & Stutzer, 2002; Diener & Scollon, 2003; and Hoorn, 2007).

Married people have high life satisfaction (Mroczek & Spiro, 2005). Never married men have unfavorable subjective well-being. Men and women in formal marriages exhibit higher life satisfaction than other forms of family arrangements. A life-long marriage is the most satisfying (Evans & Kelley, 2004).

The benefits of marriage have been explained via its status as a structural form of social support (House et al., 1988). Marriage represents a social contract that bonds individuals together in an intimate relationship that can be stress-buffering and socially integrative. Classic studies operationalized social support via marriage (as well as civic and religious participation), finding that married adults were at reduced risk for premature mortality and physical morbidity (e.g., cardiovascular disease) (Stroebe & Stroebe, 1995).

There is an expansive literature on the linkages between marriage and various dimensions of physical and mental health. Waite & Lehrer (2003) provide a detailed overview of mechanisms whereby marriage may produce positive outcomes. Social integration and social support are two mechanisms highlighted by these authors and others for explaining the benefits of marriage (Coombs, 1991; and Zimmermann & Easterlin, 2006).

Rowe & Kahn (1997) found that marital status is related to life satisfaction. Chipperfield & Havens (2001) found that elderly people who had a spouse had greater life satisfaction than those who did not, and for those who stayed unmarried. Change in marital status is related to changes in life satisfaction trajectory (Mroczek & Spiro, 2005).
Kousha & Mohseni (1997) explored life satisfaction among married and unmarried Iranian women in urban areas. A series of path analysis and cross tabulations suggested that for married women life satisfaction was directly linked to their satisfaction with marriage, employment, and their leisure experiences. For unmarried women, satisfaction was affected by their leisure experiences and educational level. The study suggested that any effort to reduce or increase the educational, employment, or leisure activities of women would directly affect women's general satisfaction and therefore would affect Iranian society as a whole.

A clear positive link has been established between marriage and subjective well-being which seems to apply to all populations; it holds true even when a number of other demographic variables are controlled and appears to be consistent over time (Haring-Hidore et al. 1985; Clark & Oswald, 1994; Lucas et al., 1996; and Diener et al., 2000).

GENDER AND LIFE SATISFACTION

The traditional sociological emphasis on gender roles has been augmented in recent decades by theoretical and empirical development yielding new perspectives that direct attention to master roles, gender ideology, "doing gender", and gender structure (Risman, 1998).

There are biological differences between men and women. Socio-biologists argue that gender differences are attributable to differences in psychology and biology. During childhood and adolescence, girls as a group tend to be happier than boys. One of the most important reasons for this is that girls get their life satisfaction from interpersonal relationships, while boys’ greatest life satisfaction comes from achievement. During the early years of adulthood, women tend to be more satisfied in life than men, especially if they are married and feel useful as mothers and wives. Young men by contrast tend to be less satisfied in their lives because they are often not able to achieve the success in their occupation that they
had hoped for. After forty, the reverse is true for many women, especially those whose role has been that of home maker. By contrast, many men become happier and better satisfied in their lives after forty because they feel more successful in their careers than when they were younger. Then there is a shift in happiness and life satisfaction after sixty or sixty-five. Men rebel against feeling useless, while many women feel more useful, either in taking care of retired or ailing husband, or helping with the care of grand children.

Development of social skills and relationships often differs by gender, starting at an early age (Eisenberg et al., 1991, Benenson, 1996; and Roberts & Strayer, 1996). Starting as early as age five, females tend to better at peaceful conflict resolution than males (Miller et al., 1986, and Ohubuchi & Yamamoto, 1990). Hall (1979) and Noller (1986) assert that females have greater ability than males to accommodate others, greater empathy, greater expressiveness, greater breadth in using emotional information, and subordinate role in the larger culture.

Gender is a statistically significant predictor of subjective well-being. The relationship between social class and subjective well-being is reduced when gender is used as a covariate (Haring et al., 1984). Women tend to rate social needs as more important than do men, while men tend to consider pay more important than do women. Women are subjectively satisfied with their pay in spite of objective underpayment, the paradox of the contented female worker (Crosby, 1982; and Major & Konar, 1984).

Muzamil & Tasia (2008) found that women had average level of life satisfaction at all age levels. It is found that with an increase in age, the overall life satisfaction decreases whereas, with an increase in personal income, the overall life satisfaction increases. Moreover, with an increase in family income, the overall life satisfaction of women also increases.

In general, studies have reported no significant effects for gender on life satisfaction (Pavot et al., 1991; Shek, 1995; Hamarat et al., 2001; and Zhang, 2005).
This reflects the finding in the meta-analytic study of Haring et al. (1984) that showed gender not to be a major determinant of subjective well-being. However, a few studies had found women reporting lower levels of life satisfaction compared to men. These include Blake & Darling (2000) study in African Americans, the study of Hutchinson et al. (2004), and Neto & Barros’s (2007) study in adolescents from Portuguese immigrant families in Switzerland. Dorahy et al. (1996), on the other hand, reported that Indian females scored higher on life satisfaction than their male counterparts. Perhaps, gender differences in life satisfaction may be related to cultural and contextual variables.

A number of studies have reported that life satisfaction does not vary by gender (Andrews & Whitney, 1976; Campbell et al., 1976; Diener & Diener, 1995; and Diener & Scollon, 2003), or argue that they have disappeared in recent decades (Frey & Stutzer, 2002). On the other hand, some researchers have found that women use more social resources in the prediction of life satisfaction than men (Diener & Fujita, 1995; Gibson et al., 1997, Gerdtham & Johannesson, 2001; Frey & Stutzer, 2002; and Hoorn, 2007), while Plagnol & Easterlin (2008) had found that men were more satisfied with their financial status and family than women. Further, they had found that there were no major differences in the judgments about life satisfaction among males and females, but they might rely on different resources in the evaluation of their life satisfaction.

Studies on gender differences in the impact of marital quality on individual well-being have also yielded mixed findings. An early study found that while marital status was more beneficial for men than women, the relation between marital quality and well-being (measured by overall life satisfaction, mental health, and home life satisfaction) was found to be stronger for women than men (Gove et al., 1983). However, in a recent longitudinal study, Umberson et al. (2006) reported that marital quality did not have a differential impact on the health of men and women over the life course. Umberson et al. (2005) stated that "although the
impact of marital quality on physical health trajectories may be similar for married men and women, generally lower levels of marital quality experienced by women may translate into a sustained disadvantage for the health of married women over the life course”. Whisman (2001) review on marital quality and depressive symptomatology found that men and women were negatively affected by marital distress cohort effects. Given the longer history of research on marital quality, the differences between men and women may be inconsistent across different age cohorts. However, more recent studies in marital therapy have continued to find marital distress preceding depressive symptomatology more for women (Kung, 2000; and Mead, 2002). Other lab-based clinical studies also showed that marital conflict had stronger adverse effects on women than men (Kiecolt-Glaser et al., 1987; and Kiecolt-Glaser et al., 1998).

Researchers have also found that women receive less emotional support from their husbands than men do from their wives (Solomon & Rothblum, 1986; and Vinokur & Vinokur-Kaplan, 1990). Thus, it is not surprising that marriage appears to be less beneficial for women than for men. Specifically, married women report poorer mental and physical health (Gove, 1973) and less marital satisfaction than married men do (Voydanoff & Donnelly, 1999; and Moor & Komter, 2012). Rather than marriage per se, marital quality appears to be more important for women's well-being (Williams, 1988). Husaini et al. (1982) found that the one situation in which marriage is beneficial for women is when the husband is rated as highly supportive.

Many empirical studies provide additional evidence on how various dimensions of gender may condition the effects of marital and parental status on well-being. Umberson et al. (2010) concluded that stressors associated with young children were experienced more negatively by mothers than fathers. This conclusion is consistent with earlier work reporting that the mothers of young children report lower levels of well-being than fathers of young children (Glenn & McLanahan, 1981; and Simon, 1998).
Oshio (2012) investigated gender differences in the associations of life satisfaction with family and social relations among the Japanese elderly. It was found that men were less satisfied with life when living without their spouse; women were less satisfied with life when they lived and/or had close relations with their parents-in-law; coresidence with an unmarried son was negatively associated with life satisfaction for both men and women; and a larger number of friends and social activities enhanced life satisfaction for women but not for men. Men were more sensitive than women to overall family relations, while the relative importance of social relations was higher for women.