DAILY LIFE PHYSICAL ACTIVITY

Movement of energy is essential for a person's functioning. In the physical body, energy flow is associated with the movement of skeletal muscles. In fact, a broad definition of physical activity is “any bodily movement produced by skeletal muscles that results in energy expenditure” (Caspersen, 1985). Numerous short bouts of moderate physical activity can be planned into activities of daily living has been called lifestyle physical activity (Pender, 2002).

Scientific evidence clearly demonstrates that regular, moderate intensity physical activity provides substantial healthy benefits. However, low levels of physical activity continue to be a major public health challenge in almost every population group of developed countries (Dubbert, 2002). Therefore, it is important that integrative health promotion activities include the encouragement and facilitation of physical activity and exercise by children and adults.

Many people erroneously believe that to reap health benefits they must engage in vigorous, continuous exercise, although it is clear that regular moderate physical activity provides substantial health benefits. Pate and Colleagues (1995) suggest that 30 minutes or more of moderate intensity physical activity is needed on most, preferably all, days of the week. Physical activity can accumulated in relatively short bouts, enough to expend approximately 200 calories per day (e.g. walking briskly at 3 to 4 mph), conditioning exercise or general clasithenics, or home care and general cleaning.

Physical exercise has been defined as “a subset of physical activity that is planned, structured, and repetitive and has as a final or intermediate objective towards the improvement or maintenance of physical fitness” (Caspersen, 1985). Therefore, physical exercise is a specific form of physical activity associated with desired outcomes of fitness, flexibility, and balance.

Physical activity is a broad term that encompasses all forms of muscle movements. These movements can range from sports of lifestyle activities. Furthermore, exercise can be defined as physical activity that is planned, structured movement of the body designed to enhance fitness. Exercise may be classified in one of two categories, anaerobic and aerobic, depending on way energy is derived.
from. There is a distinct difference between the two, and specific technique are used
to enhance both. Anerobic exercise does not require oxygen for energy. This is due to
intensity and duration of anaerobic events, which typically are high intensity and last
only a few to a minute or two. These activities range from a tennis serve to an eight-
hundred meter run. Aerobic exercise does require oxygen for energy. This is
observed during exercise that is less intensity and of longer duration. This energy
system is primarily used during events lasting longer than several minutes, such as a
two-mile run or bicycle race.

The American college of Sports Medicine (ACSM), the centers of disease
control and prevention (CDC), and the surgeon general have all issued statements
that recommend placing an emphasis on adopting physical activity into one’s
lifestyle. Their intention is to make the public more aware of health benefits
associated with increased by physical activity, as well as to highlight the amount and
intensity of activity necessary to achieve optimal benefits.

Exercise improves the cardiovascular system: improves the strength,
endurance, and flexibility of the muscular system; induces positive changes in the
skeletal digestive, and immune body systems; and lowers serum lipids and blood
pressure (Zelasko, 1995).

A good exercise program would include three states. The first stage in warm
up, where one should complete light calisthenics to activate and warm the muscles,
immediately followed by stretching, which helps to maintain flexibility. The second
stage is the conditioning stage, which consists of cardionasual work to enhance the
function of the heart and lungs and a resistance-training to strengthen and tone major
muscle groups, such as the quadriceps, hamstings, chest, biceps, back and
abdominals. The final stage consists of a cool down, or reduction in heart rate to rest
as well as stretching again, since the greatest modification in flexibility comes from
post-exercise stretching.

According to Caspersen, Powell and Christenson (1985), being physically fit
is “the ability to carry out daily tasks with vigor and alertness, without under fatigue
and with ample energy to enjoy leisure time pursuits and to meet unforeseen
emergencies.” Physical fitness encompasses cardiorespiratory and muscular
endurance, muscular strength, body composition, and flexibility. Strength is the ability of a muscle or muscle group to exert force against resistance (Griffin, 1998).

Flexibility is “the capacity of a joint to move freely through a full range of motion without under stress” (1998), while balance involves the ability to maintain equilibrium while standing still or moving (Caspersen, 1985).

Even intermittent activity confers substantial benefits. The recommended 30 minutes of activity can be accumulated in short bouts of activity, such as 8 to 10 minutes of walking up the stairs instead of taking the devator, walking instead of driving short distances, doing calisthenics, or pedaling a stationary cycle while watching television. Gardening, housework, raking leaves, dancing and playing actively with children can also contribute to the 30 minute per day total in performed at an intensity that corresponds to brisk walking.

Defining Physical Activity and Fitness

Physical activity refers to all energy expended by movement. The major contributors are everyday activities that involve moving the body around, such as walking, cycling, climbing stairs, housework and shopping with much of it occurring as an incidental part of our routines. Fidgeting may be important in overall energy expenditure but is not usually included.

Exercise, on the other hand, is a planned and purposeful attempt, at least in part, to improve fitness and health. It might include activities such as brisk walking, cycling, aerobic dance, and perhaps active hobbies such as gardening and competitive sports.

Unlike physical activity and exercise, which are behavioural processes, physical fitness is a set of attributes, such as strength or stamina, that determine capacity for physical activity. Fitness is largely the result of our levels of physical activity, and programmes of exercise can be devised to improve specific aspects of fitness. Fitness, however, is also a result of genetic factors, with some lucky individuals having a natural capacity and physique to excel at physical challenges.

This becomes more noticeable in competitive sports, such as distance running, or lifting weight where the best performers have a genetically superior body that is in peak condition through vigorous training. Evidence to date, however,
suggests that it is regular participation in physical activity rather than any inherited component of fitness that is related to health (Hein, Suadicini, and Gyntelberg, 1992). Those individuals who feel protected by their past athletic achievements, unfortunately appear to be misled! Similarly, those who feel that they cannot benefit from exercise because they are not athletic or ‘sporty’ are also mistaken.

**What are the Cost of Inactivity?**

The human form is clearly designed for physical activity so perhaps we should not be surprised that in a chronic sedentary state it shows signs of failure. In the past 20 years or so extensive epidemiological and experimental evidence has established that inactivity causes illness and premature death. Recently, Lee and Skerrett (2001) reviewed 44 prospective investigations and identified a consistent dose-response relationship between physical activity and/or aerobic fitness and all-cause mortality. Only five investigations failed to show an effect.

Those who maintain a reasonable amount of activity, particularly across the middle and later years, are twice as likely to avoid early death and serious illness (Berlin & Colditz, 1990; Powell et al., 1987). This is on a par with avoidance of smoking, hypertension and dyslipidemia, leading to the recognition of inactivity as the fourth primary risk factor for heart disease (see Figure 1). Further good news suggests that the process of becoming fitter produces these benefits (Bijnen et al., 1999; Blair et al., 1995; Eriksson et al., 1998). It appears that it is never too late to make some changes and experience these positive outcomes.

Not only does disease and early death cause suffering to victims and their friends and family, but there are also high economic costs in terms of sickness, absence from work and health care. Most of the estimates have been conducted in the USA, where the population attributable risk caused by inactivity as been put at 18% for heart disease at a cost of $24 billion (1995 $ value) and 22% for colon cancer at a cost of $2 billion (Colditz, 1999). Average medical costs for active people are 30% lower than inactive people. In Britain the cost of obesity, which is around 20% of the population and at least partially a result of inactivity, has been estimated at £500 million, causing 18 million days of sickness absence.
The importance of physical activity in daily life is not merely limited to losing those extra kilos. It goes much beyond those 30 minutes of moderate physical activity. But first we should be clear on what we mean by physical activity. It does not merely mean the extra minutes you take out from your schedule, devoted to intense exercising. It also means the quality of life itself, measured in terms of how active you are all you need to do to be physically active is to be on the novel. Be it household activities, going for work, getting the groceries from the market and even taking the steps instead of the lift. The importance of physical activity in daily life are many. The benefits of physical activity is not just physical, but it is also emotional, mental and spiritual. An half hour brisk walk may make you feel rejuvenated and refreshed. Some of the benefits of physical activity include the following:

- Reduction of risk of heart and lung problems.
- Control of high blood pressure and high blood sugar.
- Control of blood cholesterol.
- Reduction of the threat of stroke.
- Prevention of diabetes type II.
- Reduction of mental anxiety and depression.
- Loss of weight.
- Maintain of body weight.
- In proving the self image of the person.

While these are only some benefits, the importance of physical activity in daily life is more than this. Physical activity takes you closer to the path of total fitness and overall well-being.

**WHAT ARE THE BENEFITS OF PHYSICALY ACTIVITY?**

Physical activity has both preventive and therapeutic effects across several diseases and conditions.
Coronary heart disease and stroke

Coronary heart disease (CHD) remains the leading cause of death in Europe. Maintaining an active lifestyle, and at least a moderately high level of aerobic fitness, halves the chances of either dying from or contracting serious heart disease. There is a clear dose response relationship, with the change from sedentary to moderately active producing greatest health benefits. Regular walking produces a reduction in CHD events (Sesso et al., 2000). Similarly, cycling to work (Andersen et al., 2000) active commuting to work (Vuori et al., 1994), and four hours of recreational activity per week (Wannamathee et al., 2000) or at least 800 kcals of leisure time activity per week (Haapanen et al., 19%) are all associated with reduced risk.

Physical activity is also useful for recovery from heart disease with exercise-based cardiac rehabilitation programmes effective in reducing further deaths by 27% (Jolliffe et al., 2001).

Obesity

Obesity, more than any other disease state, appears to be a direct result of recent changes in environmental conditions that involve easy access to motorised transport, labour-saving devices, home screen entertainment, and cheap, high density food. The incidence of obesity has trebled in a 20 year period to the point where 20-25% of adults are clinically obese (Body mass index >29.9). This constitutes an epidemic and is reflected in many developed countries as well as most developing nations. The evidence that reduced physical activity has been a determinant of this increase is stronger than the evidence for increased energy intake (Prentice & Jebb, 1995).

There are several prospective studies that indicate the benefits of an active and fit lifestyle for the prevention of obesity. Activity at least seems to attenuate weight gain typical of the middle years (Di Pietro, 1999; Fogelholm et al., 2000). Exercise produces modest weight loss in those already overweight or obese, adds to weight loss when combined with calorie restricted diets, and improves body composition by preserving muscle tissue and increasing fat loss (Garrow & Summerbell, 1994; Wing, 1999). Physical activity is also effective in reducing high
risk abdominal or visceral fatness (American College of Sports Medicine, 2001). Furthermore, those who maintain exercise are much more likely to sustain any weight loss long term than those who rely on dietary management alone (Wing, 1999).

Perhaps the greatest benefit of physical activity for the obese is its impact on health risk profile. Blair and Brodney (1999) reviewed observational studies and concluded that obese people who managed to keep active and fit reduced their risk of heart disease and diabetes relative to non-obese levels. This important data would suggest that it is not unhealthy to be fat as long as you remain ill. It also puts into question whether obesity is more hazardous than inactivity.

Adult onset diabetes

The incidence of Type 2 diabetes has risen rapidly. This is often attributed to the concomitant rise in obesity. However, there is strong evidence to show that inactivity may be a causal factor. Prospective studies indicate a strong dose response negative relationship between activity and contraction of diabetes, with risk reductions of 33-50% recorded for active groups (Manson et al., 1992). Walking, cycling and active hobbies such as gardening are associated with lower risk but it is likely that the greatest gains are made with moderate to vigorous activity (Lynch et al., 1996). The strong relationship is plausible as the muscle is a critical site for glucose metabolism.

Exercise has been shown to delay or possibly prevent progression of glucose intolerance to the diagnosis of diabetes (Pan et al., 1997). Exercise also has benefits for those who are already diagnosed with diabetes. A small number of well designed studies have also shown that an activity programme of walking or cycling, carried out three times a week for 30-40 minutes, is able to produce small but significant improvements in glycaemic control in diabetics.

Cancer

Cancer remains a leading cause of ill health and death. Involvement in occupational or leisure time physical activity carries a reduced risk of mortality from cancer (Thune & Furberg, 2001). Moderate to vigorous activity appears to be most
beneficial. The strongest protective effect is for colon or colorectal cancers (Lund Nilsen & Vatten, 2001) producing a 40-50% risk reduction.

The population-attributable risk for inactivity has been estimated at 22% in the USA at a cost of $24 billion (1995 figures) (Colditz, 1999). Physical activity also helps prevent lung cancer with a 40% risk reduction evident after control for smoking and other lifestyle factors. Similarly there are benefits for breast cancer but not prostate or testicular cancer.

There has been less attention paid to the impact of exercise in the treatment or management of cancer. Although there is as yet insufficient evidence to suggest that progress of the disease can be slowed by exercise, it does appear to have benefits for life quality including improved psychological well-being and reductions in fatigue and nausea.

Musculo-skeletal health

Less attention has been paid to musculoskeletal disorders and diseases such as low back pain, osteoarthritis and osteoporosis, yet they are a major cause of human suffering, reduced life quality and lost work productivity. Exercise training produces stronger muscles, tendons and ligaments and thicker more dense bone. This improves functional capacity and allows greater independent living in older people. Physical activity programmes designed to improve muscular strength also helps older adults to maintain balance (Snow, 2000) and this in turn can produce a reduction in falls. It can be effective in preventing low back pain and also reduces reoccurrence of back problems (Vuori, 2001). At this point it is not clear which type of exercise works best.

Physical activity has not been shown to prevent osteo-arthritis but walking programmes have indicated important beneficial effects. Exercise can reduce pain, stiffness and disability and improve strength, mobility and overall ratings of life quality (Hartman et al., 2000).

Exercise training involving, weight bearing moderate to vigorous activity, can increase bone mineral density and bone size in adolescents, help maintain it in adults and slow decline in older age. This in turn prevents or delays the onset of
osteoporosis but cannot reverse osteoporosis once it has developed. The effect is specific to those bones loaded by the exercise (Vuori, 2001).

**Mental well-being**

The case for physical activity and health has largely been made on the evidence for its prevention of diseases such as CHD, cancer, obesity and diabetes. The World Health Organization has estimated that mental illness, largely in the form of depression and anxiety, will be the leading cause of disability and a major cause of loss of life by the year 2020. In addition to increased incidence of serious mental illness there is concern for the increasing numbers of 'worried well' who suffer chronic or recurrent mild to moderate symptoms. Several well designed studies have now shown that physical activity can reduce clinical depression (Mutrie, 2000).

Exercise can be as effective as traditional treatment such as psychotherapy. It can offer a cheap alternative for those who do not wish to rely on medication, and it brings extra physical health benefits to a population who are at elevated risk for several diseases. A few prospective studies indicate that maintaining physical activity over several years can also provide a reduced risk (up to 22%) of subsequent depression (Dunn et al., 2001).

Physical activity also improves psychological well-being in those who are not suffering from serious mental disorders. Several hundreds of studies (see Biddle, Fox, & Boutcher, 2000) have documented improvements in subjective well-being, mood and emotions, and self-perceptions such as body image, physical self-worth and self-esteem. Furthermore, both single bouts of activity and exercise training reduce anxiety and improve reactivity to stress, and also improve quality and length of sleep in those with or without sleep disorders.

Physical activity is particularly helpful for older people as it reduces risk of dementia and Alzheimer disease (Laurin et al., 2001) and improves executive aspects of mental functioning such as planning, short-term memory and decision making (Kramer et al., 1999). Clearly, physical activity has tremendous potential to improve quality of life throughout the lifespan.
Risks of Physical Activity

The risk of sudden cardiac death is elevated by five times during vigorous exercise for fit individuals and 56 times for unfit individuals. Any risks accompanying exercise are far outweighed by the benefits and the reductions in disease risk that fitness brings (Vuori, 1995). There is also an increased risk of injury, particularly to feet, ankles and knees, while taking part in exercise or vigorous sports.

Finally, much press attention has been about at the prospect of exercise addiction, whereby people become 'hooked' on exercise to the detriment of other aspect of life such as work and social relationships. Although a syndrome of exercise dependence has been identified, it is extremely rare and more likely to accompany other mental problems such as anorexia nervosa, excessive neuroticism and obsessive-compulsive disorders (Szabo, 2000).

Morris (1994) recently suggested that physical activity promotion provides today's best buy in the health market place. Sedentary living is becoming increasingly widespread and its toll is already evident. When people become more active, the reduce their risk of early death from heart disease, some cancers and diabetes, they manage their weight better, increase their tolerance for physical work, and they improve their muscle and bone health. They are also likely to improve their psychological well-being and life quality. Not only does physical activity have the potential to add years to life, but the evidence is also accumulating that it can add life to years.

Researchers have consistently reported strong evidence of the positive physical and psychological outcomes for people who engage in regular physical activity (e.g., Biddle & Mutrie, 2001; Buckworth & Dishman, 2002). According to Armstrong, Bauman, and Davies (2000) few people consistently incorporate physical activity into their lives and some (40% of Australian women 45-59 years) resist or avoid doing exercise despite the potential benefits (O'Brien-Cousin & Gillis, 2005). A paradox exists whereby people know about the potential benefits of physical activity and the health risks associated with inactivity and with obesity yet inactivity and obesity rates are consistently rising. When people attempt to change unhealthy, behaviours such as low physical activity or sedentariness, multiple cycling and
recycling through numerous unsuccessful attempts occurs frequently. Failed attempts to change can result in discouragement that further reduces motivation for physical activity (Biddle and Mutrie 2002). People are often drawn into sporadic attempts to change yet find their new levels of physical activity unsustainable. These attempts to change are unsustainable for many reasons including, lack of time, ill-health, and perceived psychosocial barriers, all of which affect motivation for physical activity. It is essential to identify how to increase motivation for people to increase and sustain physical activity levels. The need to identify effective motivators of physical activity adoption and maintenance is particularly urgent for women because they have been identified as most likely to become and remain physically inactive (Armstrong et al. 2000).

Based on extensive research evidence of the positive effects physical activity can exert on physical and mental conditions, health professionals encourage people to engage in regular physical activity. For example, physical activity decreases the risk of chronic illnesses (Cardiovascular Disease (CVD), type 2 Diabetes, Chronic Respiratory Disease (CRD)), obesity (McInnis, Franklin, & Rippe, 2003) and death (McElroy, 2002; Yach et al., 2005). Yach et al. reported the staggering figure that physical inactivity-related diseases are associated with more than 50 percent of worldwide deaths.

The conceptual nature of daily life physical activity variable states that an individual’s engagement in physical exercise like yoga/aerobics etc. makes him to have high self efficacy i.e. positive belief and evaluation of one self.

**SELF-EFFICACY**

In 1977, the famous psychologist Albert Bandura at Standford University introduced the concept of perceived self efficacy in the context of cognitive behaviour modification. It has been found that strong sense of personal efficacy is related to better health, higher achievement, and more social integration. This concept has been applied to such diverse areas as school achievement, emotional disorders, mental and physical health, and sociopolitical change.
Behavioural change is facilitated by a personal sense of control. If people believe that they can take action to solve a problem instrumentally, they become more inclined to do so and feel more committed to this decision. While outcome expectancies refer to the perception of the possible consequences of one’s action, perceived self-efficacy pertains to personal action control or agency (Bandur, 1992; Maddux, 1991, 1993). A person who believes in being able to cause an event can conduct a more active and self-determined life course. This “can do” cognition mirrors a sense of control over one’s capacity to deal with stress.

Self-efficacy makes a difference in how people feel, thin and act. In terms of feeling, a low sense of self-efficacy is associated with depression, anxiety, and helplessness. Such individuals also have low self-esteem and harbour pessimistic thoughts about their accomplishments and personal development. In terms of thinking, a strong sense of competence facilitates cognitive processes and academic performance. Self-efficacy levels can enhance or impede the motivation to act. Individuals with high self-efficacy choose to perform more challenging tasks. They set themselves higher goals and stick to them (Locke and Latham, 1990). Actions are preshaped in thought, and people anticipate either optimistic or pessimistic scenarios in line with their level of self-efficacy. Once an action has been taken, high self-efficacious persons invest more effort and persist longer than those with low self-efficacy. When setbacks occur, the former recover more quickly and maintain the commitment to their goals. Self-efficacy also allows people to select challenging settings, explore their environments, or create new situations. A sense of competence can be acquired by mastery experience, vicarious experience, verbal persuasion, or physiological feedback (Bandura, 1977). Self-efficacy, however, is venture some behaviour that is within reach of one’s capabilities.

Bandura (1977a, 1977b) proposed that favourable self evaluations become associated with other forms of reinforcements. The person develop a sense of self efficacy. The feeling of being effective in coping with the environment. People who have low sense of self-efficacy do not expect to be effective and may therefore avoid tasks or easily give up when attempting to solve problems.

Self-efficacy is one of the aspects of self that influence self-regulation. According to Bandura (1986) that self-efficacy is the expectation that we hold about
our abilities to accomplish certain tasks. Whether we undertake a particular activity or strive to meet a particular goals depends on whether we believe we will be efficacious in performing those actions.

Psychologists believe that early experiences with success and failure lead people to develop fairly stable conceptions of their self-efficacy in different life domains (Bandura 1986).

Self-efficacy theory (Bandura, 1977) suggests that there are four major sources of information used by individuals when forming self-efficacy judgments (see Figure). In order of strength, the first is performance accomplishments, which refers to personal assessment information that is based on an individual's personal mastery accomplishments (i.e., past experiences with the specific task being investigated). Previous successes raise mastery expectations, while repeated failures lower them (Gist & Mitchell, 1992; Saks, 1995; Silver, Mitchell & Gist, 1995). The second is vicarious experience, which is gained by observing others perform activities successfully. This is often referred to as modeling, and it can generate expectations in observers that they can improve their own performance by learning from what they have observed (Bandura, 1978; Gist & Mitchell, 1992). Social persuasion is the third, and it refers to activities where people are led, through suggestion, into believing that they can cope successfully with specific tasks. Coaching and giving evaluative feedback on performance are common types of social persuasion (Bandura, 1977; Bandura & Cervone, 1986). The final source of information is physiological and emotional states. The individual's physiological or emotional states influence self-efficacy judgments with respect to specific tasks. Emotional reactions to such tasks (e.g., anxiety) can lead to negative judgments of one's ability to complete the tasks (Bandura, 1988).
Bandura (1982) reviewed a variety of different lines of self-efficacy research, and concluded that self-efficacy theory has considerable potential explanatory power. His review found that perceived self-efficacy helps to account for a wide variety of individual behaviors, including: changes in coping behavior produced by different modes of influence, levels of physiological stress reactions, self-regulation, achievement strivings, growth of intrinsic interest, and choice of career pursuits.

Self-efficacy has been shown to apply across a wide range of situations and is a good predictor of subsequent performance and behavior (Bandura, 1978, Gist & Mitchell, 1992). From his observation of the results from various experiments, Bandura (1982, p. 61) concluded that "perceived efficacy is often a better predictor of behavior in generalization tests than is past performance. ... Behavior is raw data that must be cognitively appraised for its efficacy value." Other authors (Gist, 1989;
Gist, Schwoerer, & Rosen, 1989; Locke, 1991) have also concluded that the empirical evidence supporting self-efficacy theory is very strong.

**Clarifications and Distinctions**

I. Self-efficacy versus self-efficacy beliefs, assessments, or expectations. Self-efficacy as a theoretically derived construct can be considered to be any or a combination of the above definitions, but is generally the notion of one’s complete concept of his or her ability to perform a type of task related to a particular context and domain. Self-efficacy beliefs or expectations, however, are the item-specific tasks and measurements of one’s beliefs that such tasks can be performed. Self-efficacy beliefs or expectations combine together to form one’s overall concept of self-efficacy.

Self-efficacy versus efficacy. Unlike efficacy, which is the power to produce an effect - in essence, competence - self-efficacy is the belief (whether or not accurate) that one has the power to produce that effect by completing a given task or activity related to that competency. For example, a person with high self-efficacy may engage in a more health-related activity when an illness occurs, whereas a person with low self-efficacy would harbor feelings of hopelessness.

Self-efficacy versus self-esteem. There is a distinction between self-esteem and self-efficacy. Self-efficacy relates to a person’s perception of their ability to reach a goal, whereas self-esteem relates to a person’s sense of self-worth. For example, a person who is a terrible rock climber would probably have poor self-efficacy with regard to rock climbing, but this need not affect that person’s self-esteem since most people don’t invest much of their self-esteem in this activity. On the other hand, one might have enormous skill at rock climbing, yet set such a high standard for oneself that self-esteem is low. At the same time, a person who has high self-efficacy in general but is poor at rock climbing might think that he/she is good at rock climbing, or might still believe that he/she could quickly learn.

Self-efficacy versus confidence. Albert Bandura argues, “the construct of self-efficacy differs from the colloquial term "confidence." Confidence is a
nonspecific term that refers to strength of belief but does not necessarily specify what the certainty is about. I can be supremely confident that I will fail at an endeavor. Perceived self-efficacy refers to belief in one's agentive capabilities, that one can produce given levels of attainment. A self-efficacy belief, therefore, includes both an affirmation of a capability level and the strength of that belief. Confidence is a catchword rather than a construct embedded in a theoretical system. A helpful clarifying example is that a person's confidence statement may be that they are good at math; that same person's self-efficacy beliefs may be about the upcoming algebra exam and its particular questions.

Self-efficacy versus self-concept. Self-efficacy is concerned with beliefs of personal capability, they are judgments of one's capabilities to perform given actions. Self-concept, however, is measured at a more general level of specificity and includes the evaluation of such competence and the feelings of self-worth associated with the behaviors in question.

Generalizations of the Concept

Social Self-efficacy. Social self-efficacy is "an individual's confidence in her/his ability to engage in the social interactional tasks necessary to initiate and maintain interpersonal relationships." As a construct social self-efficacy has been variably defined, described, and measured in the scientific literature as researchers began to generalize Bandura's theory for specific applications. For example, Smith and Betz measured social self-efficacy using an instrument they developed and tested called the Scale of Perceived Social Self-Efficacy (PSSE), which they described as a measure of self-efficacy expectations with respect to a range of social behaviors. They argued that extant attempts to measure the construct were either "psychometrically inadequate or somewhat narrow in definition and scope", particularly when applied to various target populations, and thus they created the PSSE scale. Their instrument measured six domains: (1) making friends, (2) pursuing romantic relationships, (3) social assertiveness, (4) performance in public situations, (5) groups or parties, and (6) giving or receiving help. Additionally, Matsushima and Shiomi modified an instrument used in a different study in such a way that they felt it captured and measured the construct of social self-efficacy.
Some of the item domains for this instrument included Self-confidence about Social Skill in Personal Relationship, Trust in Friends, and Trust by Friends. Both sets of authors suggest that social self-efficacy is strongly correlated to the constructs of shyness and social anxiety, the measure of self-efficacy having a heavy impact upon that of the others.

Academic Self-efficacy. Academic self-efficacy refers to a student’s belief that he or she can successfully engage in and complete course-specific academic tasks, such as accomplishing course outcomes, demonstrating competency skills used in the course, satisfactorily completing assignments, passing the course, and meeting the requirements to continue on in his or her major. Various empirical inquiries have also been conducted attempting to measure academic self-efficacy.

How self-efficacy affects human function

Choices regarding behavior

People will be more inclined to take on a task if they believe they can succeed. People generally avoid tasks where their self-efficacy is low, but will engage in tasks where their self-efficacy is high. People with a self-efficacy significantly beyond their actual ability often overestimate their ability to complete tasks, which can lead to difficulties. On the other hand, people with a self-efficacy significantly lower than their ability are unlikely to grow and expand their skills. Research shows that the ‘optimum’ level of self-efficacy is a little above ability, which encourages people to tackle challenging tasks and gain valuable experience.

Motivation

People with high self-efficacy in a task are more likely to make more of an effort, and persist longer, than those with low efficacy. The stronger the self-efficacy or mastery expectations, the more active the efforts. On the other hand, low self-efficacy provides an incentive to learn more about the subject. As a result, someone with a high self-efficacy may not prepare sufficiently for a task.

Thought patterns & responses

Low self-efficacy can lead people to believe tasks are harder than they actually are.[27] This often results in poor task planning, as well as increased stress.
Observational evidence shows that people become erratic and unpredictable when engaging in a task in which they have low self-efficacy. On the other hand, people with high self-efficacy often take a wider overview of a task in order to take the best route of action. People with high self-efficacy are shown to be encouraged by obstacles to make a greater effort. Self-efficacy also affects how people respond to failure. A person with a high self-efficacy will attribute the failure to external factors, where a person with low self-efficacy will attribute failure to low ability. For example; a person with high self-efficacy in regards to mathematics may attribute a poor result to a harder than usual test, feeling sick, lack of effort or insufficient preparation. A person with a low self-efficacy will attribute the result to poor ability in mathematics. See Attribution Theory.

Health Behaviors

Health behaviors such as non-smoking, physical exercise, dieting, condom use, dental hygiene, seat belt use, or breast self-examination are, among others, dependent on one’s level of perceived self-efficacy (Conner & Norman, 2005). Self-efficacy beliefs are cognitions that determine whether health behavior change will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and failures. Self-efficacy influences the effort one puts forth to change risk behavior and the persistence to continue striving despite barriers and setbacks that may undermine motivation. Self-efficacy is directly related to health behavior, but it also affects health behaviors indirectly through its impact on goals. Self-efficacy influences the challenges that people take on as well as how high they set their goals (e.g., "I intend to reduce my smoking," or "I intend to quit smoking altogether"). A number of studies on the adoption of health practices have measured self-efficacy to assess its potential influences in initiating behavior change (Luszczynska, & Schwarzer, 2005). Often single-item measures or very brief scales (e.g., 4 items) have been used. It is actually not necessary to use larger scales if a specific behavior is to be predicted. More important is rigorous theory-based item wording. A rule of thumb is to use the following semantic structure: "I am certain that I can do xx, even if yy (barrier)" (Schwarzer, 2008). If the target behavior is less specific, one can either use more items that jointly cover the area of interest, or develop a few specific sub-scales. Whereas general self-efficacy measures refer to
the ability to deal with a variety of stressful situations, measures of self-efficacy for health behaviors refer to beliefs about the ability to perform certain health behaviors. These behaviors may be defined broadly (i.e., healthy food consumption) or in a narrow way (i.e., consumption of high-fibre food).

The Destiny Idea

Bandura showed that people of differing self-efficacy perceive the world in fundamentally different ways. People with a high self-efficacy are generally of the opinion that they are in control of their own lives; that their own actions and decisions shape their lives. On the other hand, people with low self-efficacy may see their lives as somewhat out of their hands.

Development of Efficacy Beliefs

Bandura has put forth four main forms that influence development of self-efficacy in human beings. The first and most effective way to creating a strong sense of efficacy is through mastery experiences. They provide the most reliable testimony whether one can master whatever it takes to succeed (Bandura, 1982, Biran and Wilson, 1981, Gist, 1989). Successes build a robust belief in one's personal efficacy, failures undermine it, especially, if failures occur before the sense of efficacy is firmly established. Development a sense of efficacy through mastery experiences is not a matter of adopting ready-made habits. Rather it involves acquiring the cognitive, behavioural and self-regulatory tools for creating and executing appropriate courses of action to manage ever changing life circumstances.

Vicarious experiences provided by social models is the second influential way of creating and strengthening efficacy beliefs. Seeing people similar to themselves succeeding by perseverant efforts raises observers' beliefs that they too, posses the capabilities to master comparable activities (Bandura, 1986; Schunk, 1986). By the same token, observing others failing despite high efforts, lowers observers, judgments of their own efficacy and undermines their level of motivation (Brown and Inouye, 1978). The impact of modeling on beliefs of personal efficacy is strongly influenced by perceived similarity to the models. The greater the assumed similarity, the more persuasive are the model's successes and failures.
Social persuasion is the third way of strengthening people's beliefs that they have what it takes to success. People who are persuaded verbally that they possess the capabilities to master given activities are likely to mobilize greater effort and sustain it, than, if, they harbor self-doubts and dwell on personal deficiencies when problems arise (Litt, 1988, Schunk, 1986). To the extent that persuasive boost in perceived self-efficacy lead people to try hard enough to succeed, self-affirming beliefs promote development of skills and a sense of personal efficacy.

The fourth way of altering efficacy beliefs is to enhance physical status, reduce stress and negative emotional proclivities, and correct misinterpretations of bodily states. People also rely on their physiological and emotional states in judging their capabilities. They interpret their stress reactions and tensions as signs of vulnerability to poor performance. Ewart (1992) observed that in activities involving strength and stamina, people judge their fatigue, aches, and pains as sign of physical debility. Mood also affects people's judgments of their personal efficacy. Positive mood enhances perceived self-efficacy: despondent mood diminishes it here (Kavanagh and Bower, 1985). Thus, efficacy beliefs can be altered by strengthening physical status, reducing stress and negative emotional proclivities and correcting misinterpretations of one's bodily states.

**Self-Efficacy: The Major Processes**

Efficacy beliefs regulate human functioning through four major processes: cognitive, motivational, affective and selection processes, which operate collectively in some what integrated manner.

**Cognitive Processes**

Human behaviour being purposive is governed by fore thought embodying valued goals. Personal goal setting is influenced by self-appraisal of capabilities. According to Locke and Latham (1990) the stronger the perceived self-efficacy, the higher the goals people set for themselves and the former is their commitment to them.
Most courses of actions are initially organized in thoughts. Person’s efficacy beliefs guide and shape the future course of action which he visualizes, constructs and is likely to undertake. People holding high personal efficacy beliefs visualize success and set positive guides and follow them in behaviour. Those who doubt their personal efficacy, visualize failure and do things that may go wrong because it is difficult to achieve much while fighting self-doubts. Wood and Bandura (1989) observed that self-referent beliefs help people in managing difficult environmental demands under taxing circumstances. Individuals with low sense of efficacy become more and more erratic in their thinking and lower their aspirations resulting in poor performance. Contrary to it, those who possess the robust sense of efficacy set challenging goals, use good analytical thinking which pays off in performing accomplishments.

Motivational Processes

Efficacy beliefs play a key role in regulating self motivation. Most human motivation is cognitively generated. People motivate themselves, set their goals, guide their actions and anticipate probable outcomes of their actions. There are three different forms of cognitive motivators around which different theories have been developed. They include causal attributions, outcome expectancies and cognized goals. The corresponding theories are attribution theory, expectancy value theory and goal setting theory respectively. Efficacy beliefs operate in each of these type of cognitive motivation. Efficacy beliefs influence causal attribution (Alden, 1986, Grove, 1993, McAuley, 1991). People who regard themselves as highly efficacious, attribute their failures to insufficient effort or adverse situational conditions, where as those who regard them-selves as inefficacious tend to attribute their failures to low ability. Causal attributions not only affect motivation, but also affective reactions and performance mainly through beliefs of personal efficacy (Chwalisz, Altmaier & Russell, 1992, Schunk & Gunn, 1986).

The expectancy value theory, posits that individuals expect that a given action/behaviour would produce certain outcomes and they place value on these outcomes. People act on their beliefs about what they can do as well as their beliefs about the probable outcomes of performance. Besides, expectancy, Vroom (1964)
introduced the concepts of valence and instrumentality in his expectancy theory. By valence, he meant the strength of an individual's effort for a particular outcome. Instrumentality refers to the use of specific outcome for the achievement of ultimate goal. The important point is that expectant outcomes are greatly governed by one's efficacy beliefs and by using the influence of perceived self-efficacy beliefs, the utility of expectancy value theory has been substantially enhanced (Dzewaltowski, Noble and Shaw, 1990, Schwarzer, 1992).

Goals set, give direction to individual's behaviour and maintain his persistence for achievement. Explicit and challenging goals enhance motivation (Locke and Latham, 1990). Goal-setting theory posits that goals operate largely through self-influence processes and the motivation behind goal-setting involves a process of cognitive comparison of perceived performance to an adopted personal standard. By making self-satisfaction conditional on matching the standard, people give direction to their behaviour and create incentives to persist in their efforts until they obtain their goals. Bandura and Cervone, 1986) maintained that motivation based on personal standards is governed by three type of self-influences, which are: Self-satisfying and self-dissatisfying reactions to one's performance, perceived self-efficacy for goal attainment and readjustment of personal goals based on one's progress. Thus the self-efficacy beliefs of the individual contribute to his motivation in several ways.

**Affective Processes**

Individual's beliefs in their coping capabilities determine how much stresses and strain they can endure in threatening situations. Perceived self-efficacy in exercising control over stressors plays a central role in anxiety arousal (Bandura, 1991 b). Efficacy beliefs affect person's vigilance toward potential threats and how they are perceived and cognitively processed. People who believe potential threats as unmanageable, feel threatened by many aspects of their environment, view their coping capabilities inadequate and exaggerate the severity of probable threats. Because of their inefficacious thinking, they distress themselves and impair their
level of functioning (Lazarus & Folkman, 1984, Meichenbaum, 1977, Sarason, 1975) more than those who possess high self-efficacy beliefs.

In contrast, individuals of high efficacy beliefs are neither watchful for probable environmental threats nor do they feel disturbed because they believe that they have the potential to exercise control over these threats.

Self-efficacy beliefs also regulate anxiety arousal/depression by exercising control over ruminative and disturbing thoughts. It is not generally the sheer occurrence of disturbing thoughts rather the perceived inability of the person to turn them off that causes distress (Kent and Gibbons, 1987). Moreover, perceived thought control efficacy predicts anxiety when variations in frequency of aversive thoughts are removed. Both perceived coping self-efficacy and thought control efficacy operate jointly to reduce anxiety and avoidant behaviour (Ozer and Bandura, 1990).

People are partly the product of their environment and their efficacy beliefs help them in choosing the type of activities and environments they wish to get into and thus, shaping the course of their lives takes place. People with high sense of efficacy readily undertake challenging activities and select environment they judge themselves capable of managing and avoid activities and environments they believe exceed their coping capabilities.

People who have a low sense of efficacy in given domains shy away from difficult tasks, which they view as personal threats. They have low aspirations and weak commitment to the goals they choose to pursue. When faced with difficult tasks, they dwell on their personal deficiencies, the obstacles they are likely to face and all kinds of adverse outcomes rather than concentrate on how to perform them successfully. They tend to decrease their efforts and surrender easily in the face of difficulties and if they face setback, they are very slow to recover their sense of efficacy and easily fall prey to stress and depression.

In contrast, the high self-efficacious persons enhance their accomplishments and personal well-being in many ways. They accept difficult job as challenges to be mastered rather than the threats to be avoided. Individuals with high self-efficacy deal more effectively with difficulties and persist in the face of failure (Gist, 1989),
they are more likely to attain valued outcomes and thus derive satisfaction from their jobs.

Strong efficacy beliefs are not produced merely by verbally proclaiming it, rather it is a product of a complex process of self-persuasion that relies on cognitively processing of diverse sources of information and once formed improve the quality of human life to a great extent.

The coping efficacy beliefs are gaining much impetus in organizational and health psychology. Bandura (1986) has showed that coping efficacy of phobic persons can be raised through guided mastery treatment. The application of the concept can also be made in organizations where working is relatively more strenuous, i.e. where employees have direct transaction with human beings as recipients and clients etc. Because of the complex interaction of many factors, individuals working in such professions are more susceptible to be emotional exhausted having reduced feelings of personal accomplishment. Enhancing the coping efficacy of such individuals may reduce the chances of their further mental degeneration. So, self-efficacy concept is of vital importance not only to study the motivation and performance of individuals, but also for the maintenance and enhancement of their mental health.

Efficacy beliefs reduce or eliminate anxiety by supporting effective methods of behaviour that change threatening environment into a safer one. It is through the impact of efficacy beliefs on behaviour that regulates stress and anxiety. The stronger the sense of efficacy, the more bold are the people in taking on the problematic situations that generate stress and the greater will be probability of their success in shaping their behaviour more to their volition and health.

HEALTHINESS

Health is difficult to define. In many definitions physiological and psychological components of health are dichotomized. Other subconcepts that might be included in the definitions of health include environmental and social influence, freedom from pain or disease, optimum capability, ability to adapt, purposeful of well-being. Within the disease perspective, health has been defined as a state or
condition of integrity of functioning (functional capacity or ability) and perceived well-being (feeling well). The term health has been derived from word ‘hoelth’ means sound, and ‘hale’ means strength. Consequently a person is able to:-

- Function adequately (can be objectively observed).
- Adapt adequately to the environment.
- Feel well (as subjectively assessed).

Health is the general condition of a person in all aspects. It is also a level of functional and/or metabolic efficiency of an organism, often implicitly human. In 1986, the WHO, in the Ottawa Charter for Health Promotion, said that the health is, “a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities.”

More or less health is viewed as state of being. It can be dichotomized into wellness or illness. Normal health status is viewed as a standard of adequacy to access capabilities for role or task performance. When health is dichotomized into wellness or illness, it is viewed as a continuum from an idea state of high-level wellness to terminal illness and death.

Overall health is achieved through a combination of physical, mental, emotional, and social well-being, which, together is commonly referred to as the health triangle.

The Lalonde report suggests that there are four general determinants of health including human biology, environment, lifestyle and healthcare services. Thus, health is maintained and improved not only through the advancement and application of health science, but also through the efforts and intelligent lifestyle choices of the individual and society.

Smith (1981) indicated that many people hold beliefs from all four models of health concurrently. These four models of health are the clinical model, the role performance model, the adaptive model and the eudemonistic model.

According to clinical model, people are seen as physiological systems with interrelated functions. Health is identified as the absence of signs and symptoms of medically defined disease or disability; people are healthy if they are not ill. Thus
health can be defined as a, “State of not being sick” (Ardell, 1997) or “a relatively passive state of freedom from illness.... A condition of relative homeostasis” (Dunn, 1977).

According to the role performance model, the critical criterion of health is the person’s ability of the maximum expected performance. If a person is able to perform, this inability means illness even if the individual appears clinically healthy.

According to the adaptive model, health is perceived as a condition in which a person is engaged in effective interaction with the physical and social environment. Here, the adaptive meaning of health is related to ability to adjust, i.e., persons are healthy if they are able to cope.

The fourth model, i.e., the eudemonistic model of health is considered to be the most comprehensive conception of health (Smith 1981). This model stresses that health is a condition of actualization or realization of the person’s potential. Health “transcends biological fitness. It is primarily a measure of each person’s ability to do and become what he wants to become” (Dubos, 1978). Woods and colleagues (1992) identified characteristics consistent with the eudiamonistic meaning of health including having goods, positive self-concept, positive body image, social involvement positive mood, harmony energy, healthy life ways, creativity and rational thinking. The above four models of health as freedom from illness, ability to fulfill roles in the society with the maximum ability to adjust and cope, plus actualization of acquired and interest potential in one self.

The Theory of Healthiness was given by Leddy (1996). Health is conceptualized, according to this theory, as a dynamically changing life process in human being. Healthiness is one of the manifestation of health pattern, that can be defined as a measurable process characterized by mutual process among perceived purpose, connections and the power to achieve goals. “Healthiness reflects a human beings perceived involvement in shaping change experienced in living. Therefore, healthiness is a resource that influence the ongoing patterning reflected in health.” (Leddy, 1997).

There are three dimensions of healthiness, i.e. purpose, connections and power to achieve goals.
Purpose

It's a person’s attribution of significance and direction to the pattern of human-environment mutual process (participation). It has two dimensions, i.e.) (a) meaningfulness as connections and the characterization of an aspect of the present or the desired future as having meaning, importance or value and (b) ends, defined as goals that a person aims to reach or accomplish.

Meaning indicates both the comprehension of words, concepts, or an experience and an appreciation of the significance of what is understood or perceived by individual or group.

In terms of purpose, meaning can be described as beliefs that organize, justify, and direct a person’s striving. According to, goals (the other concept that, with meaning, comprise purpose in healthiness theory) constitute a central element of a person’s meaning system.

Three commonly accepted defining characteristics of meaning are purpose (the present has meaning because of the connection with the future events), value (provides a sense of goodness or positiveness to life and can provide a justification for a particular course of action), and personal worth (Baumeister and Vohs, 1998). When an outcome perspective is adopted, meaning is viewed as coming from extrinsic things that a person wishes to accomplish or have. In contrast, when a
process oriented perspective is used, it helps a person to understand why life experiences are significant and meaningful (King, 2004).

"To be lived well, life must have purpose" (Ryff and Singer, 1998). Goals can reflect core values, are associated with projects and pursuits that give meaning in the present and promote hope for the future, and facilitate the realization of an individual’s potential. Purpose in life and personal growth are not only contributors to health but in fact are characteristic features of health (Griffith and Graham, 2004; Ryff and Singer, 1998).

Goals are studied mostly on the basis of expectancy-value models of motivation. According to these models, efforts require sufficient confidence in the eventual attainment of a goal (expectancy), and also a goal that matters enough (value) (Carver and Scheier, 2003).

Thus, a sense of optimism leads to confidence about successful outcomes; this results in persistence of efforts to accomplish goals.

Motivation is critical variable in producing and maintaining change (Ryan and Deci, 2000). Intrinsic motivation is an inherent tendency to seek out novelty and challenges, to extend and exercise one’s capacities; to explore, learn and achieve personal growth, happiness and meaningful relationships; and to make a contribution to society (Baner and McAdams, 2004; Ryan and Deci, 2000).

Tangible rewards, threats, deadlines, directives pressured evaluations, and imposed goals diminish intrinsic motivation, while choice, acknowledgement of feelings, and opportunities for self-direction enhance intrinsic motivation by increasing feelings of autonomy.

**Connections**

Connectedness occurs when a person is actively involved with another person (inter personal), object, group (social), or environment (natural or man-made) and that involvement promotes a sense of comfort, well-being and reduced anxiety (Hagerly Lynch- Sauer, Patusky and Bauwsema, 1993). Connectedness occurs through the dynamics of an independent and interrelated relationship.

The concepts which is used interchangeably with connection is relatedness. Relatedness refers to an individual’s involvement with other people, groups or the
natural environment (Patusky, 2000). Relatedness expresses an individual’s worldview beyond his or her own sense of self, involving connection and commitment to an outside entity (other human or spiritual being) or the environment (natural, physical or social) (Hanley and Abell, 2002).

Patusky (2002) describes a nested ecological approach consisting of levels of relatedness: the macrosystem (societal beliefs), microsystem (family unit), ecosystem (groups that affect the immediate setting, e.g., work) and ontogenetic (individual development). Within each level, four states of relatedness have been identified: connectedness (comfortable involvement), disconnectedness, parolesism, and enmeshment. Competencies that were associated with these states included synchrony, sense of belonging, reciprocity and mutuality (Patusky, 2002).

Power
Human being gains power by channeling energy actively, which is the perceived ability to direct energy toward the achievement of goals. It incorporates the dimensions of challenge as opportunity excitement, curiosity and involvement of its change toward meaningful goals, confidence as an assurance of the ability to overcome obstacles successfully while achieving goals; capacity quality of available energy; choice-freedom and creativity to select from among alternatives for actions; capability to function, ability to work play and carryout daily life activities, and control ability to influence the role, amount, and predictability to change.

Confidence is a strong positive belief about oneself what leads to increased persistence and perseverance toward goals. Confidence is closely related to self-image and the cognitive decision making process behind taking action (Kear, 2000).

Self-confidence helps to buffer performance anxiety. Hanlon, Mellalieu, and Hall (2004). Found that in the absence of self-confidence, increases in competitive anxiety intensity were perceived as outside of the performer’s control and debilitating to performance. Under conditions of high self-confidence, increases in symptoms were reported to lead to positive perceptions of control and facilitative interpretations. To protect against debilitating interpretations of competitive anxiety, performers reported the use of cognitive management strategies including mental rehearsal, thought stopping, and positive self-talk.
Capacity is composed of both vital and metabolic energy. It enables a “quantity” of material matter and the movement necessary for process. It is an active strength, expressed in vigor and vitality. Capacity can be decreased by factors such as conflict, stress, illness symptoms (e.g. Pain and Fatigue) and unbalanced nutrition. And it can be increased by contact with outdoor natural environments, relatedness, enjoyable physical activity, a nutrition diet and non-invasive therapeutic modalities (e.g. meditation, yoga and imagery) that facilitates cohmners and harmony. Capacity has reciprocal relationship with the other strengths in the healthiness theory. It “energizes” the other strengths, as it is rejuvenated by them.

Another strength of healthiness theory is choice, which means freedom to rather than freedom from and it involves non-interference, meaning that no constrains are imposed on an individual in the exercise of his or her liberty. According to Bavetta and Del Seta, 2001, choice is not about being able to choose between the two, but it is about one’s choice to choose totally unrestrictedly and autonomously among given alternatives Suzuki 2002, mentioned the value of choice is that it will lead to source thing. Knowledge for performance in a particular content area. Other, more written mastery of one’s own language and mathematical knowledge, reading competence for rapid acquisition and concrete processing of written information, media competence, independent learning strategies, social competencies and divergent thinking, critical judgements, and self-criticism.

Capacity is influenced by choice, control, and confidence in the ability to accomplish goals because a person views himself or herself as capable of shaping motives, behaviour, and future possibilities. It does not indicate skill or proficiency in task as it has no action component. High self-efficacy and healthiness both lead to positive affects, i.e. happiness.

HAPPINESS

According to Cornelius (1996), “Happiness is one of the Big Six” emotions (seven if you count contempt) which also include surprise, fear, disgust, anger, and sadness. There are two viewpoints regarding happiness. Hedonism, a psychological theory states that, organisms are motivated to seek pleasure and avoid pain (Franken, 1994). Hedonism usually involves the feelings that result from input into the five different sensory systems (vision, hearing, taste, touch and smell).
Therefore according to Hedonistic viewpoint happiness is defined as maximization of the positive affects of the different sensory systems. On the other hand Lazarous, a cognitive emotion theorist, defines happiness as that emotion which results from “making reasonable progress towards the realization of a goal” (Franken, 1994). According to cognitive theorists viewpoint, happiness is something which one experience on the way to a goal, so happiness is a goal-driven or goal motivated, while hedonists see happiness as the end state or the goal state itself.

Happiness, or subjective well-being, refers to the cognitive and affective evaluations of one's own life (Diener, 1984, 1994). Happiness is defined in terms of global life satisfaction, presence of positive affect and absence of negative affect.

All the three components (different in construct) are substantially correlated and research suggests a higher order factor (Diener, 1994; Sheldon and Lyubomirsky); which is referred to as happiness. Happiness is a state of mind or feeling characterized by contentment, love, satisfaction, pleasure or joy. A variety of philosophical, religious, psychological and biological approaches have striven to define happiness and identify its sources. Philosophers and religious thinkers often define happiness in terms of living a good life, or flourishing, rather than simply as an emotion.

Positive psychology researchers use theoretical models that include describing happiness as consisting of positive emotions and positive activities, or that describe three kinds of happiness: pleasure, engagement and meaning. Research has identified a number of attributes that correlate with happiness: relationships and social interaction, extraversion, marital status, employment, health, democratic freedom, optimism, religious involvement, income and proximity to other happy people.

Further biochemical viewpoint states that high concentrations of the neurotransmitter norepinephrine leads to feelings of elation and euphoria (extreme happiness) (Franken, 1994). The human brain has also been found to have a “reward system”. Studies with humans have shown that high levels of some neurotransmitters (specifically norepinephrine) can increase feelings of elation and euphoria (happiness) while low levels of norepinephrine have been linked to feelings of depression (unhappiness) (Franken, 1994).
There is one another perspective of happiness, i.e., learned component. Davis (1973) and Howley (1976), successfully coping with a challenge increases the amount of norepinephrine released in the brain. For instance, aerobic exercise (which is used a a coping strategy by many persons) can actually stimulate the output of norepinephrine by as much as four one half times normal.

**CONCEPT OF HAPPINESS**

**Meanings of the word**

When used in a broad sense, the word happiness is synonymous with 'quality of life' or 'well-being'. In this meaning it denotes that life is good, but does not specify what is good about life. The word is also used in more specific ways, and these can be clarified with the help of the classification of qualities of life presented below.

<table>
<thead>
<tr>
<th>Four qualities of life</th>
<th>Outer qualities</th>
<th>Inner qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-chances</td>
<td>Livability of environment</td>
<td>Life-ability of the person</td>
</tr>
<tr>
<td>Life-results</td>
<td>Utility of life</td>
<td>Satisfaction</td>
</tr>
</tbody>
</table>

Source: Veenhoven 2000

**Four qualities of life**

This classification of meanings depends on two distinctions. Vertically there is a difference between chances for a good life and actual outcomes of life. Horizontally there is a distinction between 'external' and 'internal' qualities. Together, these distinctions mark four qualities of life, all of which have been denoted by the word 'happiness'.

**Livability of the environment**

The left top quadrant denotes the meaning of good living conditions. Often the terms 'quality-of-life' and 'wellbeing' are used in this particular meaning,
especially in the writings of ecologists and sociologists. Economists sometimes use the term 'welfare' for this meaning. 'Livability' is a better word, because it refers explicitly to a characteristic of the environment. Politicians and social reformers typically stress this quality of life and sometimes refer to it as happiness.

Life-ability of the person

The right top quadrant denotes inner life-chances. That is: how well we are equipped to cope with the problems of life. This aspect of the good life is also known by different names. Especially doctors and psychologists also use the terms 'quality of life' and 'wellbeing' to denote this specific meaning. There are more names however. In biology the phenomenon is referred to as 'adaptive potential'. On other occasions it is denoted by the medical term 'health', in the medium variant of the word. Sen (1992) calls this quality of life variant 'capability'.

Utility of life

The left bottom quadrant represents the notion that a good life must be good for something more than itself. This presumes some higher value, such as ecological preservation or cultural development. Moral advisors emphasize this quality of life. This usefulness of life has also been denoted with the word happiness.

Satisfaction with life

Finally, the bottom right quadrant represents the inner outcomes of life. That is the quality in the eye of the beholder. As we deal with conscious humans this quality boils down to subjective appreciation of life. This is commonly referred to by terms such as 'subjective wellbeing', 'life-satisfaction' and also 'happiness'.

Four kinds of satisfaction

This brings the question of what 'satisfaction' is precisely. This is also a word with multiple meanings and again we can elucidate these meaning using a simple scheme. Scheme 2 is based on two distinctions; vertically between satisfaction with 'parts' of life versus satisfaction with life 'as-a-whole', and horizontally between 'passing' satisfaction and 'enduring' satisfaction. These two bipartitions yield again a four-fold taxonomy.
Four kinds of satisfaction

<table>
<thead>
<tr>
<th></th>
<th>Passing</th>
<th>Enduring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part of life</td>
<td>Pleasure</td>
<td>Part-satisfaction</td>
</tr>
<tr>
<td>Life-as-a-whole</td>
<td>Top-experience</td>
<td>Life-satisfaction</td>
</tr>
</tbody>
</table>

**Pleasures**

Passing satisfaction with a part of life is called 'pleasure'. Pleasures can be sensoric, such as a glass of good wine, or mental, such as the reading of this text. The idea that we should maximize such satisfactions is called 'hedonism'. The term happiness is sometimes used in this sense and then denotes a particular pleasant experience.

**Part-satisfactions**

Enduring satisfaction with a part of life is referred to as 'part-satisfaction'. Such satisfactions can concern a domain of life, such as working-life, and aspects of life, such as its variety. Sometimes the word happiness is used for such part-satisfactions, in particular for satisfaction with one's career.

**Top-experience**

Passing satisfaction can be about life-as-a-whole, in particular when the experience is intense, pervasive and 'oceanic'. This ecstatic kind of satisfaction is usually referred to as 'top-experience' or 'bliss'. When poets write about happiness they usually describe an experience of this kind. Likewise religious writings use the word happiness often in the sense of a mystical ecstasis. Another word for this type of satisfaction is 'Enlightenment'.

**Life-satisfaction**

Enduring satisfaction with one's life-as-a-whole is called 'life-satisfaction' and also commonly referred to as 'happiness' and as 'subjective wellbeing.'
Definitions of happiness as life-satisfaction

This brings the question what ‘life-satisfaction’ is precisely. A review of the various definitions reveals that this concept is often linked to mental processes supposed to be involved, definitions of happiness reflecting theories of happiness.

Affective definitions

Several definitions depict happiness as an affective phenomenon. For instance Wessman & Ricks (1966: 240/1) wrote: "Happiness appears as an overall evaluation of the quality of the individual’s own experience in the conduct of his vital affairs. As such, happiness represents a conception abstracted from the flux of affective life, indicating a decided balance or positive affectivity over long periods of time". It is an overall evaluation made by the individual in accounting all his pleasant and unpleasant experiences in the recent past. These definitions are close to Jeremy Bentham’s (1789) famous definition of happiness as ‘the sum of pleasures and pains’, which also involves the notion of an ‘affect balance’. A contemporary variation on this theme is proposed by Daniel Kahneman’s (2000) in the notion of ‘objective happiness’, which is the ‘raw’ affective experience that underlies the overall evaluation of life.

Cognitive definitions

Happiness is also defined as a cognitive phenomenon, that is, as the result of a deliberate evaluation process. In that vein McDowel & Newell (1987: 204) describe life-satisfaction as a “Personal assessment of one’s condition compared to an external reference standard or to one’s aspirations”. Likewise, Shin & Johnson (1978: 478) defined life-satisfaction as a “global assessment of a person’s quality of life according to his chosen criteria”. Some of the definitions in this line stress the active achievement of life goals (e.g. Annas, 2004), while others rather stress the absence of unfulfilled aspirations, e.g. Schmitz (1930: 234) who depicted happiness as: a “..state of being without desires”. In all conceptualizations happiness is deemed to be higher, the smaller the distance between standard and reality.
**Attitudinal definitions**

Happiness has also been depicted as a happy disposition and as a positive attitude towards life. Before even the age of 18, an individual becomes geared to a certain stable level of satisfaction, which — within a rather broad range of environmental circumstances — he maintains throughout life. Some of these definitions of this kind stress the consistency in affective response, while others rather see it as a belief system.

**Mixed definitions**

Several definitions combine one or more of the above elements. For instance Diener defines Subjective Well-Being (SWB) as being satisfied with life (attitude), while feeling good (affect), in his own words: “Thus a person is said to have high SWB if she or he experiences life satisfaction and frequent joy, and only infrequently experiences unpleasant emotions such as sadness or anger. Contrariwise, a person is said to have low SWB if she or he is dissatisfied with life, experiences little joy and affection and frequently feels negative emotions such as anger or anxiety” (Diener et al 1997: 25). All three elements are involved in Chekola’s (1974: 2002) definition of happiness as “.. realization of a life-plan and the absence of seriously felt dissatisfaction and an attitude of being displeased with or disliking one’s life’. Likewise Sumner’s (1997: 145/6) describes ‘being happy’ as ”..having a certain kind of positive attitude toward your life, which in the fullest form has both a cognitive and an affective component. The cognitive aspect of happiness consists in a positive evaluation of your life, a judgment that at least on balance; it measures up favorably against your standard or expectations... The affective side of happiness consists in what we commonly call a sense of well-being, finding your life enriching or rewarding or feeling satisfied or fulfilled by it.”

**Overall happiness**

Overall happiness is defined as “the degree to which an individual judges the overall quality of his life-as-a-whole favorably” (Veenhoven 1984: 22-24). Thus defined happiness appears as an attitude towards one’s own life, that has some stability of its own and that involve related feelings and beliefs. These feelings and beliefs are seen as ‘components’ of happiness.
Components of happiness

When evaluating their lives, people can use two more or less distinct sources of information: their affects and their thoughts. We can 'observe' that we feel fine most of the time, and we can also 'judge' that life seems to meet our (conscious) demands. These appraisals do not necessarily coincide. We may feel fine generally, but nevertheless be aware that we failed to realize our aspirations. Or we may have surpassed our aspirations, but nevertheless feel miserable. The relative weight in the overall evaluation is variable in principle; it is an empirical question to what extend one component dominates the other.

Hedonic level of affect

We experience different kinds of affects: feelings, emotions and moods and these experiences have different dimensions, such as active - inactive and pleasant - unpleasant. That latter dimension is called 'hedonic tone'. When we assess how well we feel we typically estimate the pleasantness in feelings, in emotions, as well as in moods. I call this 'hedonic level of affect' and this concept fits the above mentioned 'affective' definitions of happiness.

A person's average hedonic level of affect can be assessed over different periods of time: an hour, a week, a year as well as over a lifetime. The focus here is on 'current' hedonic level. This concept does not presume subjective awareness of that average level. One can feel good most of the time, without being fully aware of that. Therefore this concept can be applied to beings who cannot reflect on their own life, such as animals and little children.

Figure 1.3 : Happiness and its components
Contentment

Unlike animals and little children most adults can also evaluate their life with the use of reason and compare life-as-it-is with notions of how one wants-life-to be. The degree to which an individual perceives his wants to be met is called 'contentment' and this concept equals the above mentioned 'cognitive' definitions of happiness.

This concept presupposes that the individual has developed some conscious wants and has formed an idea about their realization.

This conception of happiness as a ‘trinity’ helps to place different theories about how we asses how happy we are.

SET-POINT THEORIES OF HAPPINESS

Set-point theories of happiness hold that we programmed to experience a certain degree of happiness, largely irrespective of how well we are doing. In this view happiness just happens to us.

Variants

A classic religious version of this theory is Devine predestination, God having decided that some people will be happy and others not, just as he foresees who will enter Heaven and who will be damned to Hell. Secular variants assume that happiness is geared by mental inclinations that are also beyond a person’s control.

Genetic disposition

This variant holds that happiness is largely determined by an innate disposition to enjoy life or not. A spokesman of this view is Lykken (1999), who claims to have shown that 80??% is heritable. There is uncertainty about the nature of this disposition, some see that in the reward system of the brain and link it to positive or negative ‘affectivity’ while others hold secondary effects responsible, such as inborn physical health.

In the latter case, happiness is essentially a variable state, though it tends to remain at the same level because of constancy in its determinants.
**Personality trait**

Another current view is that happiness depends very much on personality traits, that is, predispositions to react in a certain way. One of these ways is liking things or not and Personality traits such as 'extraversion' and 'neuroticism' are seen to determine our affective reactions to and perceptions of things that happen to us. It is generally assumed that these traits have a genetic component.

In this view personality molds the evaluation of life. Personality can also affect happiness through its impact on the course of life-events, and this is central in the dynamic-equilibrium theory of Heady & Wearing (1992).

**Cultural view**

A macro-level variant is this view is that the view on life is embodied in the national character. In this line Inglehart (1990: 30) wrote that cross-national differences in happiness “reflect cognitive cultural norms, rather than individual grief and joy”.

**Homeostatic maintenance**

While the above set-point theories aim at explaining differences in happiness, there are also theories of this kind that focus at the general level of happiness. These are motivational theories that assume that we tend to maintain a comfortable level of happiness, even in adverse conditions. In that line Cummins (2002) holds that we unconsciously keep happiness between 7 and 8 on a 10-step scale, just as we maintain a body temperature of 32 degrees Celsius

**Implications**

These theories imply that there is little chance of creating greater happiness for a greater number, since happiness is a stable trait rather than a variable state and as such not responsive to external conditions. In this view one can at best try to raise that fixed level a bit, be it with genetic engineering or training. The theory also implies that there is little sense in raising happiness, since happiness is unrelated to the wider thriving of the individual. In this view being happy or not is comparable to liking chocolate or not; fine if you do but no real problem if you don’t.
COGNITIVE THEORIES OF HAPPINESS

Cognitive theories hold that happiness is a product of human thinking and reflects discrepancies between perceptions of life-as-it-is and notions of how-life-should-be. Notions of how life should be are assumed to root in collective beliefs and to vary across cultures. This view on happiness is dominant in philosophy and also pervades the thinking of many social scientists.

Tenets

The basic assumption of this theory is that happiness is based on the comparison with standards, though there is difference on the nature of these standards and ways of comparison. Another basic assumption is that collective beliefs are involved.

Comparison

The theory assumes that we have ‘standards’ of a good life and that we constantly weigh the reality of our life against these standards. Standards are presumed to be variable rather than fixed and to follow perceptions of possibilities. In other words: we would tend to judge life by what we think it can realistically be. Different theories stress different standards. In the variant of life-time comparison the focus is on whether we are doing better or worse than before. In that view a happy youth will not add to happiness in adulthood. The social comparison variant stresses how well we are doing relative to other people, and in particular people like us. In that view happiness is surpassing the Jones. Several of these theories are combined in Michalos’ (1985) ‘Multiple Discrepancies Theory’ of happiness, which assumes that we not only compare with what we want and with what others have, but also with what we need and with what we deem fair.

Social construction

The idea that we compare to standards begs the question of where these standards come from. This is typically seen as an outcome of socialization, involving the adoption of collective notions of the good life, sometimes with minor modifications. These collective notions of the good life are seen as ‘social constructions’ that draw heavily on the wider culture and shared history. In this line
some sociologists argue that happiness as such is also a social construction. In that view, happiness is a culturally variable concept, comparable to the notion of ‘beauty’.

**Reflected appraisal**

A sociological variant holds that we not only compare life our self with our own standards, but that we also appraise our life through the eyes of others, in other words, that in assessing how happy we are we estimate how happy other people think we are. If so, this enhances the salience of shared standards of the good life.

**Implications for happiness promotion**

This theory holds that happiness does not depend on objective conditions of life, but on the standards by which these conditions are judged. As such, it also implies that there is little value in happiness. One reason is that happiness may be bought by a lowering of standards, as advocated in some variants of Buddhism. A second reason is the relativistic argument that all standards of the good life are mere collective illusions, with limited appeal in a particular time and place.

Most cognitive theories imply also that there is little chance of creating greater happiness for a greater number, in particular the theories that assume that standards adjust to reality. Some variants of this theory predict that happiness will vary around the neutral level (e.g. Unger 1970), while some variants even predict that most people will be unhappy, e.g. theories that stress the social salience of success in advertisements and the news.

This theory is summarized in figure 4.
AFFECTIVE THEORIES OF HAPPINESS

Affect theory hold that happiness is a reflection of how well we feel generally. In this view we do not ‘calculate’ happiness, but rather ‘infer’ it, the typical heuristic being “I feel good most of the time, hence I must be happy” (Schwartz & Strack 1991).

Tenets

In this line of thought, one question is how we take stock of our affective experience. Another question is what makes us feel good or bad and this links up to the wider question about the functions of affect.

Frequency of affect

It would seem that the overall evaluation of life is geared by the most salient affective experiences and that these are typically intense affects. This view is common in fiction and is more or less implied in life-reviews. Yet research using the
Experience Sampling Method shows that it is rather the relative frequency of positive to negative affect that matters (Diener et. al 1991).

Mood as informant

How do we assess that relative frequency? The cognitive view on affect procession suggests that we compute an affect balance in some way, using estimates of frequency and duration. A competing view is that this occurs automatically and that the balance reflects in mood. In this view mood is an affective meta-signal that, contrary to feelings and emotions, is not linked to specific objects. Emotions denote an affective reaction to something and prepare the organism to a response, while negative mood signals that there may be something wrong and urge to find out what that is.

Gratification of needs

Why do we feel good or bad at all? Probably because that informs us in how well we are doing. Affects are an integral part of our adaptive repertoire and seem to be linked to the gratification of human needs. ‘Needs’ are vital requirements for survival, such as eating, bonding and exercise. Nature seems to have safeguarded the gratification of these needs with affective signals such as hunger, love and zest. In this view positive mood signals that all needs are sufficiently met at the moment. ‘Needs’ in this theory should not be equated with ‘wants’ in the above discussion of cognitive theories. Needs are inborn and universal while ‘wants’ are acquired and can de variable across cultures. Wants can concur more or less with needs.

Motivation to act

In this view negative and positive mood function as red and green lights on the human machine, indicating either that there is something wrong or that all systems are functioning properly. If so, this is likely to have behavioral consequences, negative mood urging to cautions and positive mood encouraging going on. This is what Fredrickson’s (2004) ‘broaden and built’ theory is about
Implications for happiness promotion

In this view, happiness is a desirable state, both because it signals good adaptation and because it enhances behavior that apparently works out well. This is at least so if one accepts that it is good that we live up to our nature.

In this view it is also possible to create greater happiness for a greater number. If happiness depends in the end on the gratification of human needs, we can advance happiness both by improving the livability of the environment (left top quadrant in figure 10 and by enhancing individual life-abilities (right top quadrant in figure 1). There are limits to that, but even if the average happiness of 8.2 in present day Denmark might be the highest possible level, there is still much room for improvement in the rest of the world.

This theory is summarized in figure 5.

Figure 1.5: Affect theory of how happiness is assessed

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**global assessment**

**OVERALL HAPPINESS**
Satisfaction with one’s life-as-whole

**Sub-assessment:**

**Hedonic level of affect**
Balance of pleasant and unpleasant affect

**Information basis**
Affective experience

**underlying process**
Need gratification

**Substrate**
Human nature
In his book *Authentic Happiness*, Martin Seligman, one of the founders of positive psychology, describes happiness as consisting of “positive emotions” and “positive activities”. He further categories emotions related to the past, present and future. Positive emotions relating to the past include satisfaction, contentment, pride and serenity. Positive emotions relating to the future include optimism, hope and trust. Positive emotions about the present are divided in to categories: pleasure and gratifications. The bodily and higher pleasures are “pleasures of the moment” and usually involve some external stimulus.

Some researchers, such as David T. Lykken, have found that about 50% of one’s happiness depends on one’s genes, based on studying indentical twins, whose happiness is 50% correlated even when growing up in different houses. About 10% to 15% is a result of various measurable life circumstances variables, such as socioeconomic status, marital status, health income, sex and others. The remaining
40% is a combination of unknown factors and results of actions that individuals deliberately engage in for the purpose of becoming happier. These actions may vary between persons; extroverts, for example, may benefit from placing themselves in situations involving large amounts of human interaction. Also, exercise has been shown to increase one's level of momentary subjective well being significantly.

Research suggests that there are several factors that predict happiness. Lyubomirsky et al. (2005) proposed a model that attempts to account for factors influencing the current happiness level of individuals. In this model there are three main factors that influence happiness, these are: the happiness set point, circumstances and intentional activities.

The first factors that influences happiness, set point, refers to the "the central or expected value within the person's set range (Lyubemirsky et al 2005)." Set point for happiness is assumed to be heritable, fixed and stable over time (supported by McCrae and Costa 1990; Tellegen et al., 1988). According to this model set point accounts for 50% of the variance in happiness.

The second factor that influences happiness, circumstances, refers to the "incidental but relatively stable facts of an individual's life (Lyubomirsky et al., 2005)." These include demographic (e.g., gender), geographic (e.g., where one resides) and contextual (e.g. culture) variables.) there is research showing that gender income of the individual, marital status and culture makes a difference in happiness. However, circumstantial/contextual factors accounts for about 10% of the variance in happiness (Diener et al., 1999).

The third factor that influences happiness, intentional activities, is a broad category that involves the voluntary and effortful things people do in their everyday lifes. Lyubomirsky et. al. (2005) differentiates between three types of intentional activities: cognitive, behavioural activities: cognitive, behavioural and volitional. Cognitively, one could be contemplating about good things going on in his/her life. Behaviourally one could provide instrumental support to his/her friend. Volitionally, one could develop personal goals and strive to achieve them. According to lyubomirsky et al., (2005), the common theme across the three types of activities is that all rely on the voluntary effort of the individual. The research of lyubomirsky and her colleagues and research they reviewed suggest that intentional activities
account for about 40% of the variance in happiness (Lyubomirsky et al. 2005; Sheldon and Lyubomirsky, 2006b).

Research has shown that all dimensions of the big five framework are associated with happiness to differing degrees (Compton, 1998; DeNew and Cooper, 1998; Furnham and Cheng, 1997; McCrae and Costa, 1991; Morrison, 1997; Ruiz, 2005). Among the big five, extroversion and neuroticism were consistent predictors, extroversion being positively and neuroticism being negatively correlated to happiness (Argyle, 2001; Cheng and Furnham; 2001). It was also found that conscientiousness, agreeableness and openness to experience were slightly positively correlated to happiness (Diener et al., 1999).

The general goal of being happy is more important than any specific goal that they may hope to obtain. Diener and Oishi (2004) found that being happy was rated more important than having good health, a high income or a high level of attractiveness. People desire specific outcomes because they believe that their outcomes will ultimately make them happy (Gilbert, 2006).

The general belief is that daily life physical activity contributes to happiness. Is this happiness direct or through some other mediators or moderators, is a big question. In the current scenario, women have because very health conscious. Some go to gym, do yoga, aerobics, and walk vigorously etc. Simply they have because fitness freaks. Such concern brings them happiness or simply doing daily home affairs make them happy is the research question of this research study.