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Health, the word comes from an old German word that is represented, in English, by the words hale and whole, both of which refer to a state of "Soundness of body". The New English Dictionary on Historical Principles (1901), Known as the Oxford Dictionary, defines health as "Soundness of body; that condition in which its functions are duly and efficiently discharged."

In the earliest known cultures, illness was believed to result from mystical forces and evil spirits that invaded the body. Hippocrates, at the turn of the fourth century BC, proposed humoral theory which was the first rational theory of disease. According to this theory, health of body and mind resulted from equilibrium among four bodily fluids called humors. Galen during the second century A.D. expanded the humoral theory of diseases by developing an elaborate system of pharmacology that physicians followed for almost fifteen hundred years. Galen believed that hygieia (health) or euexia (soundness) occur when there is a balance between the hot, cold, dry and wet components of the body. The four bodily humours were believed to be blood, phlegm, yellow bile and black bile which were hot and wet, cold and wet, hot and dry and cold and dry respectively. (Marks, Murray, Evans and Willing, 2000). At the same time Chinese developed an integrated system of healing, which is known today as traditional oriental medicine (TOM). TOM is founded on the principle that internal harmony is essential for good health. Ayurveda is the oldest known medical system in the world, having originated in India around the Sixth Century B.C. The word ayurveda comes from the Sanskrit roots ayuh, which means longevity, and Veda, meaning Knowledge. Ayurveda is based on the belief that health is the balance between the three bodily humors, or doshas: Vata, Pitta and Kapha (Straub, 2001).

Under the influence of medieval Church, medicine advanced very little during the Middle Ages. Scientific studies of the body (especially dissection) were forbidden, and ideas about health and disease took on religious over-tones. Illness was viewed as God's punishment for evil doing, and treatment frequently involved physical torture. In the late fifteenth century, a new age- the Renaissance was born. Beginning with the reemergence scientific inquiry, this period saw the revitalization of anatomical study
and medical practice. Scholars became more “human-centered” than “God-Centered”. One of the most influential French Philosopher of Renaissance period, Rene Descartes (17-Century) who regarded human body as a machine, advanced his theory of mind-body dualism- the belief that the mind and body are autonomous processes, each subject to different laws of causality. But he also proposed that mind and body would communicate through the pineal gland, an organ in the brain (Leahey, 1987).

During Post-Renaissance period, advances in measurement and microscopy led to several new models of disease. Morgagni (1682-1771) advanced the idea that the causes of many diseases reside in problems in the internal organs and in the muscular and skeletal systems of the body (anatomical theory). The cellular theory set by Rudolf Virchow (1821-1895) of diseases suggested that disease occurs when body cells malfunction or die. Louis Pasteur (1822-1895) discovered that bacteria often cause cells to malfunction or die, giving rise to the germ theory of disease (Straub, 2002). As the field of medicine continued to advance during the early part of twentieth century, it looked more and more to physiology and anatomy. Thus was born the biomedical model of health, which maintains that illness always has a biological cause. According to biomedical model, health is nothing more than the absence of disease. The biomedical model advanced health care significantly through focus on pathogens that cause a particular disease. However, it was unable to explain the disorders that had no observable physical cause such as those noticed by Sigmund Freud, in his early twentieth century work (Alexander, 1950). The idea that specific diseases could be caused by an individuals psychological conflicts was further advanced during the 1940’s by the work of psychoanalyst Franz Alexander (Sarafino, 1990). By the early 1970’s, a new field, behavioural medicine, began to explore the role of classical and operant conditioning in health and illness. Thus, started the contemporary trend toward viewing illness and health as multifactorial i.e. diseases are caused by interaction of several factors, rather than a single, invading bacterial or viral agent. Among these are host factors (such as genetic vulnerability), environmental factors (exposure to pollutent etc.), behavioural factors (such as diet, exercise, smoking), and psychological factors (e.g. optimism, hardiness).

Today, most of the health professionals would agree that health involves much more than simply absence of disease. It is quite possible for a person to be free of
disease but still not enjoy a vigorous, satisfying life. Health is not limited to the physical well-being. Recognizing the inadequacy of the earlier limited definition of health, the United Nations established the World Health Organization (WHO). In its 1946 charter, the WHO defined health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” This definition affirms that health is a positive, multidimensional state that involves three domains: physical health, psychological health and social health (Straub, 2002). Physical health involves having a sound, disease-free body with good cardiovascular performance, sharp senses, a vital immune system and the ability to withstand physical injury. It also includes lifestyle habits that enhance physical health. Psychological health includes ability to think clearly, having good self-esteem, and enjoying a general feeling of well-being. It includes creativity, problem solving, and emotional stability. It is also characterized by self-acceptance, openness to new ideas, and a general 'hardness' of personality. Social health includes having interpersonal skills, meaningful relationships with friends and family, and social support in time of crisis. Each domain of health is, of course, influenced by the other two domains.

Perspectives in Health and Illness

Social and historical trends have created a need for new, broader models of health and illness. Psychologists have developed several models or perspectives to provide a different way of looking at the concept of health and illness. These perspectives form a complete picture of health.

1. Life-course perspective

The life-course perspective focuses on important age-related aspects of health and illness (Jackson, 1996). In all stages of life, people face challenges to their health and overall well-being. From the moment of conception until the day one dies, each one is shaped by a unique collection of genetic, biological, and sociocultural factors. This perspective considers for example, how a pregnant woman’s use of psychoactive drugs would affect her child’s life-long development. Her child might be born early and suffer from low birth weight. Low birth weight has consequences that cost a shadow over the individual’s physical and cognitive development for many years. Among these consequences are slower motor, social and language development,
increased risk of cerebral palsy; and long-term learning difficulties (Liaw and Brooks-Gum, 1993).

This perspective also examines the leading causes of death in terms of the age groups they affect. The chronic diseases that are the leading causes of death in the overall population are more likely to affect middle-aged and elderly adults. Young people are much more likely to die from accidents or unintentional injuries. Yet another concern of this perspective is the way in which specific birth-cohort experiences influence health. A birth-cohort is a group of people who, because they were born at about sometime experience similar historical and social conditions.

2. Socio-cultural Perspective

Sociocultural perspective focuses on how social and cultural factors contribute to health and disease. Life expectancy in African Americans is estimated to be seven years less than it is for whites and rather than decreasing, it appears to have increased over time. In multiethnic cultures wide disparities exist in the life expectancy and health status of ethnic minority groups and the majority population. Some of these differences undoubtedly reflect variation in Socioeconomic Status (SES), a measure of several variables, including income, education, and occupation. For example, the highest rates of chronic disease occur among people who are at the lowest SES levels (Flack, Amaro, Jenkins, Kunitz, Levy, Mixon and Yu, 1995).

In the US National Health and Nutrition Examination Survey, Otten, Teutsch, Williamson and Marks (1990) were able to account for 31 percent of the excess mortality in blacks by several risk factors (smoking, systolic blood pressure, cholesterol level, body – mass index, alcohol intake and diabetes) and a further 38 percent by family income.

Sociocultural variation is also apparent in health-related beliefs and behaviours. For example, traditional Native American health care practices are holistic and do not distinguish separate models for mental and physical illnesses (Johnson, Anderson, Bastida, Kramer, Willian and Wong, 1995). Psychologists working from this perspective have found wide discrepancies not only among ethnic groups but also within these groups, may be due to differences in education, income, overall health and risk of diseases and death (Bagley, Angel, Dilworth-Anderson, Liu and Schinke, 1995).
3. Gender Perspective

The gender perspective deals with study of gender-specific health problems and gender barriers to health care. Men and women differ in their risk of a variety of disorders. Throughout childhood, for example, boys outnumber girls in a range of behavioural and psychological disorders, including sleep and eating problems, hyperactivity, autism, and antisocial behaviour. Conversely, from age through adulthood, girls and women outnumber boys and men in the diagnosis of depression, anxiety, and eating disorders (Ussher, 1997). Boys have elevated prenatal/early childhood death rate, a greater proportion of congenital birth defects, greater vulnerability to sex-linked disorders, a higher accident rate from childhood onwards and higher incidence of behavioural and learning disorders (Verbrugge, 1988). Furthermore, men are more likely to have unhealthy life-styles-drinking too much alcohol, smoking and eating a less-healthy diet (Wright, Harwood and Coulter, 1992).

It has commonly been observed that mortality for men occurs earlier than for women, although the extent of this difference varies across countries (Whitehead and Diderichsen, 1997). In the United Kingdom between 1987-91, mean life expectancy at birth for males, at 72.3 years, was 5.6 years less than for females (78.9 years). In the United States in 1996 the disparity was 6.2 years (Kraczler, 1997). Although in some poor countries, particularly in South Asia, men outlive women (Doyal, 1995). Comparison of cause-specific mortality for males and females clearly show that males are considerably more likely to die from cardiovascular disease, injury and poisoning- suicide, violence and AIDS. The medical profession has a long history of treating men and women differently. For example research studies have shown that women treated for heart disease are given more prescriptions, are more likely to be put through unnecessary diagnostic procedures and are more likely to receive the same quality of medical care as men (Ayanian and Epstein, 1991).

The socioculture; life-course and gender perspectives overlap that they all view health and illness as the product of interacting factors. They differ only in the factors they emphasize. Although these perspectives answer different questions about health, they complement, rather than contradict, one another. Together, they help explain human health and illness. In a sense, these perspectives are subsumed under
the biopsychosocial perspective because that model, whether directly or indirectly, deals with all the issues covered by the other perspectives.

4. Biopsychosocial Perspective

Psychologists working from the biopsychosocial perspective recognize that biological, psychological and social forces act together to determine an individual's health and vulnerability to disease that is, health and disease must be explained in terms of multiple contexts.

Biological context – All behaviour occur in biological context. The bio contributing factors include genetics, viruses, bacteria and structural defects. Psychologists draw attention to those aspects of the bodies that influence health and disease: the genetic make up and the nervous, immune, and endocrine systems.

Genes provide the blue print for biology and predispose the behaviours – healthy or unhealthy, normal or abnormal. For example, the tendency to abuse alcohol has long been known to run in some families. One reason is that alcohol dependency is at least partly genetic, although it does not seem to be linked to a single, specific gene. Instead, some people may inherit a greater sensitivity to alcohol’s physical effects, experiencing intoxication as pleasurable and the aftermath of a hangover as minor. Such people may be more likely to drink, especially in certain psychological and social contexts.

Biochemical abnormalities at all levels of hypothalamic – pituitary adrenal axis are associated with both anorexia and bulimia. These include abnormal levels of norepinephrine and other neurotransmitters that may promote clinical depression (Feva, Copeland, Schweiger and Herzog, 1989). There is also evidence that bulimia may be caused in part by disturbances in the brain’s supply of endorphins (Jonas and Gold, 1988).

Biological functions and behaviour constantly interact. For example, some individuals are more vulnerable to stress-related illnesses because they angrily react to daily hassles and other environmental “triggers”. Among men, increased amounts of the hormone testosterone are positively correlated with this type of aggressive reaction. This relationship is reciprocal: Angry outburst can also lead to elevated testosterone levels.
Psychological context – The psychological aspects of health and illness include cognitions (e.g. expectations of health), emotions (e.g. fear of treatment), and behaviours (e.g. smoking, diet, exercise or alcohol consumption). For example how well a person copes with a stressful life experience is how the event is appraised. Events that are appraised as overwhelming, pervasive and beyond one's control take a much greater toll physically and psychologically than do events that are appraised as minor challenges that are temporary and surmountable. Researchers suggest that, whether a stressful event is actually experienced or merely imagined, the body's stress response is nearly the same.

Research studies have linked temperament and personality to various diseases and health issues. Cancer-prone individuals are found to be passive, uncomplaining, and to have difficulty in expressing their emotions. As nurses, oncologists and other health care professionals have long noted, cancer patients tend to be “nice people”. Psychologists use the term Type C personality for such cancer prone individuals. Researchers have made attempts to identify specific personality traits that appear to be linked to alcohol dependence like behaviour under control or deviance proneness, negative emotionality (Sayette and Hufford, 1997).

Emotion is a subjective feeling that affects and is affected by one's thoughts, behaviour, and physiology. Some emotions are positive or pleasant, such as joy and affection, and others are negative, such as anger, fear, and sadness. Emotions relate to health and illness in many ways. For instance, people whose emotions are relatively positive are less disease prone and more likely to take good care of their health and to recover quickly from illness than those people whose emotions are relatively negative.

Social context

People live in a social world. They have relationships with individuals and with groups too. As one interacts with people, he/she affects them and they affect him/her. But the social world is larger than just the people one knows or meet, and it contains levels of social spheres such as community, family, and each level affects the other. Thus social aspects of health include social norms, pressures (e.g. peer group expectations, parental pressure), social values on health, social class, ethnicity, socioeconomic status and gender.
Sociocultural factors may explain why anorexia and bulimia occurs more often in women than in men and more often in weight-conscious western cultures, and why the prevalence of eating disorders has increased in recent years. According to the sociocultural view, dieting and disordered eating are women's understandable responses to women's social roles and to cultural ideals of beauty (Seid, 1994). The "thin is beautiful" standard is absent in many developing countries. In Niger, West Africa, for instance, fat is the beauty ideal for women, who often compete to be crowned the heaviest (Onishi, 2001). In recent years, western cultures have increasingly emphasized the positive attributes of slender bodies, in particular for women and encouraging all to adopt the behaviour and attitudes of the anorexic.

In case of chronic disease such as cancer, social support is an important social factor that influence illness. Feeling of being supported by others may serve as a buffer that mitigates the output of stress hormones and keeps the body's immune defenses strong during traumatic situations. It may also promote better health habits regular checkups, and early screening of worrisome symptoms, all of which improve a cancer victim's odd's of Survival.

Figure 1 - A diagram of the interplay of systems in the biopsychosocial model.
Source: Based on Edward P. Saraino (1988).

Biopsychosocial perspective emphasizes the mutual influence among the biological, psychological, and social contexts of health. It is also based on a systems theory of behaviour. According to this theory, health is best understood as a hierarchy
of systems in which each system is simultaneously composed of smaller subsystems and part of larger, more encompassing systems. It is sometimes called “holistic approach”. This term is derived from Greek Word holos, which means ‘whole’ (Lipowski, 1986).

The term system refers to a dynamic entity consisting of components that are continuously interrelated. As shown in the figure 1, the systems concept places smaller, simpler systems within larger, more complex ones. There are many levels of system. The person consists of biological and psychological systems, which interrelate; and each of the systems includes component systems. The person interrelates with the social systems of his or her world. Each system can affect and be affected by any of the other systems.

**Positive Health**

In recent times health has secured more optimistic and positive definition of health. As started earlier, most of health professionals would agree that health involves much more than simply absence of disease. It is quite possible for a person to be free of disease but still not enjoy a vigorous satisfying life. Researches have shown that clinical psychology for years have focused primarily on the diagnosis and treatment of psychopathology, but eliminating excess negatives does not produce happiness, it produces emptiness (Lewis, 2006). Even the great historian of medicine, Henry Sigerist (1941) defined health in positive terms, “Health is ........ not simply the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of responsibilities that life put upon the individual.” This statement tries to establish health as a state that can be described conceptually at least, in positive terms, not merely as absence of negative elements.

In this new millennium Positive Psychology, Christened in 1998 by Seligman, emerged as a challenge against the disease model of psychology. Earlier focus of psychology has been on understanding and remedy of human problems, leading to neglect of what made human life productive, enjoyable, fulfilling and worth living. The new century challenges psychology to shift to more of its intellectual energy to the study of the positive aspects of human experience. A science of positive subjective experience, of positive individual traits, and of positive institutions that
promises to improve the quality of life and also to prevent the various pathologies that arise when life is barren and meaningless.

However, positive psychology is not a new field. During the times of Socrates, Plato and Aristotle, philosophical and religious inquiry focused on “God Life”. The humanistic psychologists in 1960’s and 1970’s focused on the goals for which people strive, their awareness of their striving and the importance of rational choice in this process. The researches in 1980’s and 1990’s addressed concepts such as values, well being, self efficacy, resistance, coping strength, hardiness etc. Thus, the concepts being expounded and researched in positive psychology existed earlier also and the same have not been invented by positive psychologists.

The aim of positive Psychology is to understand and then build those factors that allow individuals, communities and societies to flourish. Positive Psychology at the subjective level is about positive experience: well-being, optimism and flow. At the individual level it is about the character strengths - the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future-mindedness, and high talent. At the group level, it is about the civic virtues and the institutions that move individuals toward better citizenship: responsibility, parenting, altruism, civility, moderation, tolerance, and work ethic.

In spite of the emphasis on positivism, Positive psychology does not de-emphasize the importance of human sufferings. In fact, the focus is on building strengths to help people to deal with suffering and illness. Research has indicated that dispositional optimism is with good health and a positive response to medical interventions for conditions such as heart disease and cancer. Happiness leads to alleviation of symptoms of depression (Seligman, Steen, Park and Peterson, 2005). Studies indicate that optimistic people are healthier and happier. Optimism and hope are predictive of physical and mental health as indexed and/or mediated by a variety of measures including subjective well-being, positive mood, immunological robustness, effective coping and health promoting behaviour (Peterson, 2000; Sheier Carver and Bridges., 2000; Snyder, 2000; Taylor, Kemeny, Reed, Bower and Gruenewald, 2000).

Health from positive perspective can be viewed as a state where a reserve of positive emotions, strengths and experiences are build up in order to enable the
individual to deal with adverse situations, sufferings and illness. Positive health can be embodied as building up of positive behaviour / experiences which provide a buffer against/or prevents illness and help the individual not only to endure and survive, but flourish. The positive, subjective experiences are associated with past (well-being, contentment and satisfaction), present (happiness and flow), and future (optimism and hope) (Carr, 2004)

**Well-being, Contentment and satisfaction**

Satisfaction, contentment, fulfillment, pride and serenity are the main positive emotions associated with the past (Seligman, 2002). Subjective well-being refers to how people evaluate their lives, and include variables such as life satisfaction and marital satisfaction, and a relative absence of unpleasant moods and emotions. A person’s evaluation of his or her life may be in the form of cognitions e.g., when a person gives conscious evaluative judgments about his or her satisfaction with life as a whole or evaluative judgments about specific aspect of his or her life such as recreation. However, an evaluation of one’s life may also be in the form of affect (people experiencing unpleasant or pleasant moods and emotions in reaction to their lives). The cognitive and affective components of subjective well being are highly interrelated. Subjective well-being (SWB) covers entire range of well-being from agony to ecstasy. SWB focuses on internal experience of the respondent and is concerned with long-term states, not just the momentary moods.

**Happiness and flow**

Happiness is a positive state of mind. The dictionary definition is “feeling of joy and pleasure mingled together”. Happiness is the overall appreciation of one’s life as a whole. Positive emotions allow to increase the tolerance for pain (Weisnberg, Raz and Hener, 1998). With the exception of severely disabled, most people adapt to their health problems relative by quickly and develop self-perceptions of their health which are consistent with their level of happiness. However, there is a growing body of evidence which shows that happiness may influence the health via it’s effect on immune system. The immune systems of happy people work more effectively than those of unhappy people (Kamen-Siegel Rodin, Seligman and Dwyer 1991; Segerstrom Taylor, Kemeny and Fahey, 1998; Stone, Cox, Napoli, Valdimarsdottir and Kennedy-Moore 1994). Evidences from longitudinal studies show that happiness
has important effects on longevity (Danner, Snowdon and Friesen, 2001; Maruuta Colligan, Malinchoc and Offord, 2000; Ostir Markides, Black and Goodwin 2000).

Flow experiences occur when one become engaged in controllable but challenging tasks (which are intrinsically motivated) that must have a good chance of completing the tasks. There must be clear goals and immediate feedback. These tasks require total concentration so one becomes deeply and effortlessly involved in them, so much so that the individual no longer thinks of worries and frustrations of everyday life. Flow experience leads to enhanced performance, creativity and higher self-esteem, subjective well-being and health.

Optimism and Hope

Optimism is expectation of good things and explaining things positively. The two main approaches to optimism are based on distinct conceptualization of optimism. At one extreme, optimism has been conceptualized as a broad personality trait characterized by general optimistic expectations (Scheier and Carver, 1985) while at the other it has been constructed as an explanatory style (Seligman, 1998). Thus dispositional optimism is individual’s stable generalized expectation that they will experience good things in life. With regard to optimism’s role in influencing health, it has been hypothesized that optimism leads to more adaptive coping with stress. Optimism has also been found to influence health through its relation with health habits (Peterson, 2000; Snyder, 2000). Professor Martin Seligman (1998) and his colleagues have conceptualized optimism as an explanatory style, rather than a broad personality trait. Explanatory style describes the causal attributions that individuals habitually make for the positive and negative events that happen in their life. Research on explanatory style has mainly examined direct relations with physical and psychological health outcomes (Peterson Seligman and Valliant, 1988; Kamen-Siegel Rodin, Seligman and Dwyer, 1991). Explanatory style is related to health through coping and perception of health problems.

Hope, a construct closely related to optimism, has been conceptualized by Snyder (2000) as involving two main components: the ability to plan pathways to desired goals despite obstacles, and agency or motivation to use these pathways. Hope is the sum of these two components. Optimism and hope are predictive of physical and mental health.
Factors Affecting Positive Health

One of the most fundamental problems in research on positive health is uncertainty about which variables are the causes and which are the consequences. Identifying factors that contribute to happiness is not a simple matter (Diener and Lucas, 1999). However, most of the variables described as causes have only been shown to be "Correlates" of Positive Health and might conceivable be consequences, or perhaps both causes and consequences.

In 1967, Wilson reviewed the limited empirical evidence regarding the "Correlates of avowed happiness." He concluded that the happy person is a "young, healthy, well educated, well-paid, extroverted, optimistic, worry-free, job morale, modest aspirations, of either sex, and of a wide range of intelligence." Since Wilson’s review thousands of studies have been conducted, and one now knows much more about the correlates of positive health and the same are discussed here.

1. Age

Although Wilson’s description of the happy individual was accurate in a number of respects, a few of Wilson’s conclusions have been overturned by subsequent research. Wilson concluded that younger people report more happiness than older people. But later studies on people of all ages reveal that no time of life is notable happier or unhappy than others (Latten, 1989). In a study that examined national probability samples from 40 nations, Diener and Suh (1998) found that although pleasant affect tended to decline with age, there were no significant trends in life satisfaction and unpleasant affect. Furthermore, decreases in positive affect may be due to the fact that most measure aroused types of pleasant emotions. If less aroused emotions such as "Contentment" and "affection" are examined, age declines may not be found (Diener and Suh, 1997). Gerdtham and Johannesson (1997), were of the view that the relationship between age and happiness is unshaped, with happiness being lowest in the age group 45-64 years.

2. Gender

Wilson (1967) discussed only one study regarding sex differences in Well-being: Gurin, Veroff and Feld’s (1960) survey in which no differences were found. In a recent meta-analysis of 146 studies, Haring, Stock and Okun (1984) showed that men were slightly happier than women, but the magnitude of this difference was very
small (mean r=0.04). Inglehart (1990), on the basis of the data collected from people in the 1980’s collaborative survey of 16 nations, reported that 80% of men and 80% of Women said they were at least “fairly satisfied with life.

3. Income

Income plays a role in well-being, though this relationship is complex. In studies of personal wealth, income change, national wealth (i.e. Gross National Product), and studies of the very wealthy, find significant correlations between wealth and emotional well-being (Diener and Suh, 1997). The relation is often larger among those at the lowest levels of income, though greater income has a small effect even beyond the subsistence level (Diener Sandvik, Seidlitz, Seidlitz and Diener, 1993). Increase in national income overtime do not lead to an increase in national level of subjective well-being, in wealthy nation such as U.S.A. (Carr, 2004).

5. Education

Education level is positively correlated with happiness and this relationship is particularly strong for low-income groups in developed countries and populations in poorer countries (Diener and Lucas, 1999). This may be because of the fact that in underdeveloped countries education confers greater differential benefits. In underdeveloped countries, people with little education may not even be able to have their basic physical needs fulfilled where as those with education may earn sufficient money to have their needs for food and shelter adequately met. In contrast, in developed countries in most instances even the poorly educated have their basic physical needs met. On the other hand, Clark and Oswald (1994) found that the highly educated were more distressed than less educated persons when these groups were unemployed. Being out of the work may be more aversive to the former group because of their higher expectations. Thus, education may interfere with well-being if it leads to expectations that cannot be met.

6. Religion and Spirituality

Moderate correlations have been found between happiness and involvement in religious activity in North American studies (Myers, 2000). People involved in religion may be happier than others for many reasons. Three reasons have been given serious consideration within psychology. Firstly, religion provides a coherent belief
system that allows people to find meaning in life and hope for the future (Seligman, 2002). Second, involvement in routine attendance at religious services and being part of a religious community provides people with social support. Third, involvement in religion is often associated with a physically and psychologically healthier lifestyle characterized by marital fidelity; prosocial altruistic behaviour (rather than criminality); moderation in eating and drinking; and a commitment to hard work.

7. Relationship

Within the broad domain of relationships marriage, kinship, close friendships are all associated with enduring happiness, well-being and health. Married people are happier than unmarried people, be they divorce, separated or never married (Myers, 2000). The least happy of all are people trapped in unhappy marriages. The happiness gap between married and unmarried women is the same as that for men. There are two explanations for the link between happiness and marriage. One explanation is that more happy people get married while more unhappy people do not because happy people are more attractive as marital partners than unhappy people. Another explanation is that marriage confers a range of benefits on people that make them happy. Marriage provides psychological and physical intimacy, a context within which to have children and build a home, a social role as a spouse and parent, and a context within which to affirm identity and create posterity. Optimism within marriage has been found to be associated with higher rates of positive interactions and predict long-term marital satisfaction.

Close supportive relationship between parents and children, between siblings, and between extended family members enhance the social support available to all family members. This social support enhances subjective well-being and from evolutionary perspective we are ‘hard wired’ to derive happiness from this contact with our kinship networks (Argyle, 2001; Buss, 2000). Also, maintaining few close friendships have been found to correlate with happiness and subjective well-being (Argyle, 2000, 2001). Cooperation with acquaintances is a potential source of happiness (Axelrod, 1984; Buss 2000).

8. Culture

Specific Cultural and Sociopolitical factors have also been found to play an important role in determining happiness (Triandis, 2000). Cultures in which there is
social equality have higher mean levels of subjective well-being. Subjective well-being is greater in individualist cultures than in collectivist cultures. Subjective well-being is also found higher in people living in stable democracy devoid of political oppression and military conflict.

9. Employment Status

Employment status is related to happiness, with employed people being happier than those who are unemployed, and people in professional and skilled jobs being happier than those in unskilled jobs (Argyle, 2001). Work is the key factor in not only providing social and financial support but also in keeping the person psychologically fit. Socio-psychological research on unemployment generally reveals lowered life satisfaction, self-esteem, psychological well-being, or increased psychological distress and cognitive problems in the unemployed persons (Mohal, 1991).

10. Social Support

Social support is an important resource in maintaining health and well-being. Supporting relationships contributes to sense of security, positive evaluations of life experiences, personal worth and competence, which in turn enhances the health (Singh, 2005). It also enhances the prospects for recovery among people who are already ill. Accumulated research in this area as a whole reveals that social support in related to various indicators of health and well-being. Indeed, people report happier feelings when with others (Pavot, Diener and Fujita, 1990).

11. Life events

The effect of life events on well-being was explored by Suh, Diener, and Fujita (1996) in a 2-year longitudinal study of 115 participants. It was found that only life events during 3 months influenced life satisfaction, and positive and negative affect. Only recent life events influenced well-being, distal life events did not correlate with well-being. However, many researches have shown that well-being is primarily determined by enduring individual characteristics rather than by external life circumstances (Costa and McCrae, 1980, 1984; Costa, Diener, Sandvik, Pavot and Fujita, 1992).
12. Geographical location and environment

Strong positive feelings are associated with being in natural rather than artificial environments. People report positive feelings in geographical locations where there is vegetation, water, Panoramic views (Ulrich Dimberg and Driver 1991). Good weather induces positive moods. When the sun is shining, when it's warm, and when there is low humidity, people report more positive moods (Cunningham, 1979). However, people do adapt to unfavourable weather conditions and across nations there is no correlation between climate and national happiness ratings. Moderate correlations have been found between the quality of housing and life satisfaction. Indicators of the quality of housing include geographical location, rooms per person and room size (Andrews and Withey, 1976; Campbell, Converse and Rogeas, 1976).

13. Personality

Personality studies of happiness show that happy and unhappy people have distinctive personality profiles (Diener and Lucas, 1999). In Western cultures happy people are extraverted, optimistic and have high self-esteem and an internal locus of control. In contrast unhappy people tend to have high levels of neuroticism. There are a number of factors which offer partial explanation for the link between extraversion and happiness (Diener and Lucas, 1999). Extraverts may have a better fit with the social environment, which requires most people to be involved in frequent social interactions. Cultural factors partially determine the types of personality factors associated with happiness. In Western individualistic cultures such as USA, self-esteem and acting in a consistent way that is congruent with one's personal beliefs are personality factors associated with high levels of subjective well-being. However, subjective well-being is not correlated with these factors in eastern collectivist societies. So, cultural values partially determine personality traits probably because these traits are associated with achieving culturally valued goals (Triandis, 2000).

These were some of the researched correlates of positive health. In fact research suggests that very few demographic factors have strong effects on health, Argyle (1999) concluded that external circumstances account for only about 15% of the variance in reports of well-being. Although external situations and circumstances matter, it appears that individual reactions to these circumstances are more important in determining positive health. It is the difference in individual reactions to events that
researchers presume personality-intelligence, as important correlates of positive health.

14. Intelligence

The most famous or infamous definition of intelligence, depending upon one’s point of view, was proposed by Boring (1923) in an article in The New Republic. Boring proposed that intelligence is what tests of intelligence test. To this day, it is not totally clear what intelligence test measure, and thus it is not clear on the basis of this definition what intelligence is. Also, tests of intelligence do not intercorrelate perfectly, and therefore they do not produce a singular entity of the kind the definition implies.

Despite the difficulty in defining and measuring human intelligence, the goal is a worth one. One method for understanding intelligence is through theory based models. Davidson and Downing (2002) described four types of contemporary models of human intelligence:

1) Neural Efficiency Model:- Many theorists believe that the heart of intelligence is actually the brain. According to this view, the neurophysiological bases of mental ability must be discovered for intelligent behaviour to be understood and properly measured. The premise behind the neural efficiency model is that highly intelligent people have brains that operate more accurately and more quickly than those less intelligent individuals. Individuals who obtain high IQ have brains that spend less energy, and consequently consume less glucose, than the brains of individuals with lower IQ scores (Haier, Siegel, Nuechterein, Hazlett, Peak, Browing and Buchsbaum, 1988).

2. Hierarchical models:- The basic assumption underlying the model is that structure of intelligence can be discovered by analyzing the interrelationship of scores on mental ability tests. Spearman (1927) found a single important factor to be related to performance on all types of mental abilities tests, general factor. He also found set of specific factors, each of which related to performance on a single type of mental ability. Thurston (1938) revealed seven independent factors or primary mental abilities. Catell’s theory (1943) of fluid and crystallized intelligence was updated to include other second order factors in its hierarchical structure (Horn, 1986). Carroll
(1993, 1996) gave his three-stratum theory, which differs notably from gf-gc theory in the inclusion of a third-order general factor at the apex of its hierarchy.

3. Contextual models: Contextual models are based on the assumption that intelligence often has different meanings and instantiation in different contexts, particularly in different cultures. Research supports this assumption by demonstrating that what is considered intelligent behaviour in one culture is sometimes thought to be rather idiotic in other cultures (Berry and Bennett, 1992; Das, 1994; Wober, 1974).

4. Complex Systems Models: These models combine biological, hierarchical, and contextual factors in their conceptualization of intelligence. According to the complex systems models, intelligence is dynamic and can change when environmental conditions change. Robert Sternberg’s triarchic theory (1985, 1988, 1997) has three interacting aspects to intelligence – internal (componential) aspect of intelligence, external (practical) aspect and experimental aspect (one’s experiences to solve relative novel problems and quickly automatize procedures). Like Sternberg, Howard Gardner (1983) rejects the conception of intelligence as a unitary ability. According to Gardner’s theory of multiple intelligence there are at least eight fairly independent types of intelligences that have evolved in the human species. However, Gardner’s theory focuses more on domains of intelligence and less on mental processes than does the triarchic theory. Some of the major kinds of intelligence that researchers are investigating today are briefly examined in the following paragraphs.

General Intelligence: Spearman’s name is almost synonym with the term general intelligence. This general intelligence, he felt, underlies all tasks. Spearman (1927) felt that the most important information to have about a person’s intellectual ability is an estimate of their ‘g’. He believed it to correspond to a fixed amount of “mental energy” than individual can assign to different tasks at different times. Spearman (1927) also found what he considered to be a less important set of specific factors (s), each of which was related to performance on a single type of mental-ability test such as arithmetic computations or vocabulary.

The theory of fluid and crystallized intelligence (gf-gc theory) clarifies Spearman’s notion of a general factor. Cattell (1943), in his gf-gc theory proposed that general intelligence has two major parts fluid intelligence (gf) and crystallized intelligence (gc). The gf factor includes the abilities that perceive relationships among
stimulus patterns, comprehend implications and to inferences from relationships. It is dependent on the efficient functioning of the central nervous system, rather than on prior experience and cultural context. Standardized tests measure this type of intelligence through analogies, series completions, and other tasks involving abstract reasoning. The gc factor which is dependent on experience and education within a culture, consists of the set of skills and knowledge that individuals acquire throughout their life spans. Standardized tests measure gc through vocabulary, general knowledge, and verbal comprehension questions. The theory has since been updated to include other second order factors in its hierarchical structure (Horn, 1986).

Contemporary to Horn, Carroll’s (1993, 1996) proposed the three-stratum theory which portrays the structure of intelligence as a pyramid. The top of the pyramid, stratum III, is the conceptual equivalent of spearman’s g. Although Carroll does not support Spearman’s interpretation of ‘g’ as representing mental energy, he agrees that g underlies all intellectual activity and has a high degree of heritability. The middle of the pyramid, stratum II, consists of eight factors that are differentially influenced by g. The base of the pyramid, stratum I, consists of numerous specific abilities such as quantitative reasoning and lexical knowledge.

Social Intelligence

As originally coined by E.L Thorndike (1920), the term referred to the persons ability to understand and manage other people and to engage in adaptive social interactions. More recently, Cantor and Kihlstrom (1987) redefined social intelligence as the individual’s fund of knowledge about the social world.

The view of social intelligence has its origins in Thorndike’s (1920) division of intelligence into three facets: the ability to understand and manage ideas (abstract intelligence), concrete objects (mechanical intelligence), and people (social intelligence). In his classic formulation: “by social intelligence is meant the ability to understand and manage men and women, boys and girls – to act wisely in human relations”. Similarly, Moss and Hunt (1927) defined social intelligence as the “ability to get along with others”. Vernon (1933) provided the most wide-ranging definition of social intelligence as the person’s “ability to get along with people in general, social technique or ease in society, knowledge of social matters, susceptibility to stimuli
from other members of a group, as well as insight into the temporary moods or underlying personality traits of strangers."

Guilford's (1967) structure of Intellect model postulated a system of 120 separate intellectual abilities based on all possible combinations of operations (cognition, memory, divergent production, convergent production and evaluation), with four categories of content (figural, symbolic, semantic, and behavioural) and six categories of products (units, classes, relations, system, transformations and implications). The symbolic and semantic content domains correspond to abstract intelligence, the figural domain to practical intelligence and the behavioural domain to social intelligence. Social intelligence is represented as 30 abilities lying in the domain of behavioural operations.

Gardner (1983) proposed the theory of multiple intelligences. According to the theory intelligence is not unitary cognitive ability but that there are seven (and perhaps more) quite different kinds of intelligence. Two are explicitly personal and social in nature i.e. interpersonal and interpersonal. Gardner defines intrapersonal intelligence as the person's ability to gain access to his or her own internal emotional life and interpersonal intelligence as the individual's ability to notice and make distinctions among other individuals.

Social intelligence played little role in Sternberg's early componential view of human intelligence (Sternberg, 1977) which was intended to focus on reasoning and problem solving skills. However, social intelligence is explicitly represented in Sternberg's more recent triarchic view of intelligence (Sternberg, 1984, 1985). According to the triarchic theory, intelligence is composed of analytical, creative and practical abilities. Practical intelligence is defined in terms of problem solving in everyday contexts and explicitly includes social intelligence (Sternberg and Wagner, 1986).

**Emotional Intelligence**

The explosion of interest in the construct arose from Daniel Goleman's (1995) best Seller- *Emotional Intelligence: why it can matter more than IQ*. This book popularized aspects of the academic work on emotional intelligence, first published by professor John Mayer, Peter Salovey and colleagues in 1990 (Mayer DiPaolo and Salovey 1990; Salovey and Mayer, 1990) and the work of professor Howard Gardner
on intrapersonal and interpersonal intelligence published in 1983. Mayer and Salovey's research findings suggest that processing information about emotions entailed abilities different from those required to process information about verbal, mathematical or visuo-spatial problems contained in traditional intelligence tests. Gardner argued that there were many other intelligences besides that measured by traditional IQ tests and these included the ability to understand and regulate one's own emotions (intrapersonal intelligence) and the ability to understand and manage relationships (interpersonal intelligence). Goleman argued that success at work and in achieving valued life goals was largely due, not to IQ, but to emotional intelligence - the capacity to recognize and manage one's own emotions and those of others in significant interpersonal relationships.

In recent research emotional intelligence has been conceptualized in two distinct ways or models. First, it has been conceptualized as ability model, which describes emotional intelligence as a set of abilities (Mayer and Salovey, 1997). Second, as mixed models describe emotional intelligence as a set of abilities and personality traits (Bar-on, 1997; Goleman, 1995, 1998).

**Mayer and Salovey and Caruso's ability model of emotional intelligence**

According to Mayer, Caruso and Salovey's (1997) ability model, emotional intelligence refers to the abilities used to process information, about one's own emotions and the emotions of others. Within the model, there are four branches: emotional perception, emotional integration, emotional understanding and emotional management. The first of these, emotional perception, is the ability to register, attend to and decipher emotional messages as they are expressed in a variety of context including facial expressions, tone of voice and works of art. The second branch, emotional integration, refers to the ability to access and generate feelings which facilitate thought. Emotional understanding, the third branch, is the ability to comprehend the implications of emotions. The fourth branch of emotional intelligence, emotional management, is the ability to regulate emotions, to chose to be open to experiencing emotions and to control the way in which these are expressed.

**Bar-On's Model of emotional intelligence**

In Professor Reuven Bar-On's (1997) model of emotional intelligence, distinctions are made between five domains: the intrapersonal, the interpersonal,
adaptability, stress management and mood. In each of these domains there are specific skills which collectively constitute what he refers to as emotional and social intelligence. Bar-On (2000) has shown that people of different ages and genders have differing EQs or EQ profiles. Emotional intelligence increases with age at least until middle life. People in their 40's and 50's have higher EQs than younger or older people. Males and females have similar overall EQs but males score higher in intrapersonal, adaptability and stress management domains while females score higher in interpersonal domain. There is also considerable evidence that high EQ scores are associated with better mental health and low EQ scores with more mental health difficulties.

Goleman's model of emotional intelligence:

Goleman's model of emotional intelligence was articulated in his two books on the subject (Goleman, 1995, 1998). Goleman created a model that was mixed and was characterized by five broad areas. These are listed in Table and include a) Knowing one's emotions, b) managing emotions, c) motivating oneself, d) recognizing emotions in others and e) handling relationships. According to him, emotional intelligence would account for success at home, at school and work.

Table 1 Three Competing Models of Emotional Intelligence

<table>
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<tr>
<td>Emotional perception</td>
<td>Intrapersonal Skill</td>
<td>Knowing One's Emotions</td>
</tr>
<tr>
<td>Emotional Integration</td>
<td>Interpersonal Skills</td>
<td>Management Emotions</td>
</tr>
<tr>
<td>Emotional understanding</td>
<td>Adaptability</td>
<td>Motivating Oneself</td>
</tr>
<tr>
<td>Emotional management</td>
<td>Stress-Management:</td>
<td>Recognizing Emotions in Others</td>
</tr>
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<td></td>
<td>General Mood</td>
<td>Handling Relationships</td>
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</table>

From the above mentioned concepts, it may be inferred that various forms of intelligence influence an individuals overall behaviour pattern-ability to reason, ability to engage in social interactions and relationships, ability to perceive,
understand and manage emotions. Intelligence level of a person influences almost each and every small or big act; therefore health status of an individual is also bound to be affected by it. Thus, in considering positive health one must take into account the role of the relatively enduring characteristics i.e. intelligence of individuals that remain largely unaffected by momentary changes in their environmental situation.

Before delving into methodological or technical aspects of the study it would be desirable if one arrives at semantic clarification of the studies conducted in the area of positive health. The chapter-II deals with review of literature.