IMPACT OF RELIGIOSITY, EGO-STRENGTH, AND SOCIAL SUPPORT ON SUBJECTIVE WELL-BEING OF THE BRONCHIAL ASTHMA AND HYPERTENSIVE PATIENTS

ABSTRACT

THESIS
SUBMITTED FOR THE AWARD OF THE DEGREE OF
Doctor of Philosophy
IN
PSYCHOLOGY

BY
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DEPARTMENT OF PSYCHOLOGY
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Non-communicable diseases like bronchial asthma and hypertension are the leading cause of death in our country. Today 15.20 million people are suffering from bronchial asthma and around 10-15% of the adult population is affected by hypertension in our country. 30 million people die annually from hypertension and other heart conditions.

The present study is designed to examine the role of various psychological factors like religiosity, ego-strength, and social support on subjective well-being of the bronchial asthma and hypertensive patients.

There is a close relationship between respiratory functions and psychological factors. The combined voluntary and involuntary control of breathing allows close involvement with psychological states. Asthmatics are generally nervous and hyper-irritable. In most recent studies adverse psychosocial factors have been found in between 60% and 86% of asthma deaths.

Psychological or psychosocial factors play an important role in rising of the blood pressure level of an individual. Presence of various psychological and psychosocial factors like religiosity, ego-strength, and social support helps in maintaining greater well-being and thus foster greater physical and mental health.
Subjective well-being is a broader measure of quality of life because it reflects deeper values beyond physical pleasure and ephemeral emotions. Subjective well-being, especially life satisfaction, is likely to reflect the person’s fulfillment of his or her values and goals, and involves the search for meaningfulness in one’s life. Health is positively related to well-being.

Religious faith can promote physical health of the patients. Praying evokes beneficial changes in the body. When people pray, they experience some decrease in blood pressure, metabolism, heart and breathing rates. Studies have shown that religious faith may provide patients with a sense of hope and well-being that things will turn out all right and thus, foster greater motivation to achieve emotional recovery.

Ego-strength is an important factor determining the capacity of an individual to perceive a challenging situation realistically, to decide the course of action rationally, and to execute the response effectively.

Health psychologists have found that family relationships play an important role for the patient’s adaptation to the seriousness of illness. The family or spouse support seems to be a vital source in the overall adjustment.
The main objectives of the present study are:

1. To determine the relationship between subjective well-being and religiosity, subjective well-being and ego strength and subjective well-being and social support, religiosity and ego strength, religiosity and social support, ego-strength and social support among male and female patients of the three comparison groups.

2. To determine the partial correlations between subjective well-being and religiosity scores, subjective well-being and ego-strength scores, subjective well-being and social support scores, religiosity and ego-strength scores, religiosity and social support scores and ego-strength and social support scores among male and female patients of the three comparison groups.

3. To determine the significance of partial coefficients of correlation at the .95 confidence interval among male and female patients of the three comparison groups.

4. To determine the multiple coefficients of correlation between scores actually earned and scores predicted on subjective well-being from the three variables—religiosity, ego-strength, and social support among male and female patients of the three comparison groups.

Important studies related to the variables of the present study have been reviewed and are discussed in detail in chapter two.
The sample of the present investigation comprised of two hundred patients. They were categorized into three main groups. Group I comprised of 70 hypertensive patients (male = 30, female = 40). Group II comprised of male (54) and female (46) patients of bronchial asthma, and group III comprise of male (15) and female (15) patients who have both bronchial asthma and hypertension. The patients were drawn from the O.P.D. and wards of Cardiology Center, and O.P.D. and wards of T.B. and respiratory diseases of the J.N. Medical College, A.M.U., Aligarh.

The following tools were used in the present study:

**Satisfaction with life Scale** (Diener, 1984), was used to measure subjective well-being of the patients. This scale comprised of 5 items with 7 point rating scale ranging form strongly agree to strongly disagree.

**Religiosty Scale** (Decker and Broota, 1985) : The religious scale measures the extent of an individuals dependency of the supernatural being and adherence to the doctrines of one’s faith. The scale consisted of 44 items out of which 25 were positive and 19 were negative.

**Ego-strength Scale** Indian adaptation of Barron’s ego-strength scale (Hasan, 1974) was used to measure ego-strength. The scale comprised of 32 items with the two alternative response categories.
Significant others Scale (SOS) developed by Power, Champion and Aris (1988), it’s a flexible instrument for the measurement of an individuals perceived support. The scale consisted of 10 items which were prefaced with the phrase “to what extent can you?”. Actual support of the respondents was measured in terms of the currently applicable relationship (spouse/parents) on each of the 10 support functions. A 1-7 scale was used from 1=never to 7=always.

The data were analysed with the help of some suitable statistical techniques such as Pearson Product Moment coefficients of correlation, partial coefficient of correlation and multiple coefficient of correlation.

The main results of the present study are:

- Positive relationship existed between subjective well-being and religiosity scores among male and female bronchial asthma patients.
- Significant positive correlation coefficients were found to exist between SWB and ego-strength scores among male and female patients of bronchial asthma and hypertension.
- Significant positive correlation coefficients were found to exist between scores obtained on SOS and ego-strength for male bronchial asthma patients.
• Multiple coefficient of correlations indicated that subjective well-being scores were significantly correlated with religiosity, ego-strength and social support among male and female patients of bronchial asthma and hypertension.

• Subjective well-being scores were correlated significantly with religiosity, ego-strength and social support scores in male patient suffering from both diseases (i.e. bronchial asthma and hypertension).
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THESIS

To My Parents
"AND WHEN I AM ILL, IT IS HE WHO CURES ME; "WHO WILL CAUSE ME TO DIE, AND THEN TO LIVE (AGAIN):

(The holy Qurān S.26, A. 80, 81)
Certificate

It is certified that Ms. Zainab has worked under our supervision for her Ph.D. Thesis entitled "Impact of Religiosity, Ego-Strength, and Social Support on Subjective well-being of the Bronchial Asthma and Hypertensive Patients". This study was carried out by her and it is an original piece of work. The thesis can be forwarded to the examiners for its evaluation.

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I feel glad to thank my Nani, Mummy and my brother Haris Furqan for being the greatest source of inspiration for me, their profound love and wholehearted cooperation have enabled me to attain the target.

I would be failing in my duty if I fail to express my inexplicable gratitude to my friends. Kehkashan, Arshi, Zeba, Shahina, Sufia, for their motivation and encouragement.

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(Zainab)
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CHAPTER - I

Introduction
Non-communicable diseases are fast replacing infectious diseases and malnutrition as the leading cause of disability and premature death in developing countries. In the developing countries, out of a little more than 39 million deaths, which occurred in 1993, more than 10 million were caused by major non communicable diseases (WHO).

Hypertension and bronchial asthma are most prevalent and life threatening disorders in the developing countries. The role of various psychological factors like religiosity, ego strength, social support on subjective well-being among hypertension and bronchial asthma patients has been examined in this study. It is therefore, important to understand the nature and causation of these diseases.

**Bronchial Asthma**

The close relationship between respiratory function and psychological factors is well known. The combined voluntary and involuntary control of breathing allows close involvement with psychological factors. From birth onwards, respiration is intimately involved in communicating with others and expressing emotions. Laughter, crying, sighing, anger, fear are expressed through variation in respiratory rate and depth

Asthma affects millions of Indians. Asthma is a common clinical problem and one of the common causes of hospitalization
in developing countries like India. The worldwide prevalence of asthma as well as its morbidity and mortality is still rising. The prevalence rates range from 0.2% and 25% with an estimated incidence between 2-5 cases per 1000 per year among all age groups. The familial nature of asthma was first recognised by Maimonides in the 12th century. Asthma and allergy are linked to genetic predisposition, environmental exposure to common allergens, respiratory infections and pollution. In Delhi, Mumbai, Calcutta, Bangalore, the mega cities of India, prevalence of asthma is more. Probably climate, environmental exposures, urbanization, changes in multiple social lifestyle and dietary factors may play an important role in rising asthma prevalence. The word asthma is of Greek derivation and it means 'panting or gasping'.

In 1991 the National Asthma Education Program Expert Panel report from the National Institute of Health defined Asthma as "a lung disease with the following characteristics:

1. Airway obstruction that is reversible, either spontaneously or with treatment.
2. Airway inflammation.
3. Increased airway responsiveness to a variety of stimuli.

According to Shivpuri (1971) bronchial asthma may be defined as a disease characterized by recurrent expiratory dyspnoea due to
wide spread narrowing of peripheral airways in the lungs and not due to any known specific infection or infestation or organic lesion. It is further characterized by a hyper-reactive bronchial tree and varies in severity over a short period of time either spontaneously or as a result of treatment.”

- Every year, Mumbaiites lose 20.2 million workdays to pollution related illness.
- 9.01 lakh people suffer from pollution related asthma
- 5,800 people are admitted to hospital for pollution related respiratory symptoms.
- 24,000 adults and 2.20 lakh children are affected by Chronic bronchitis caused by pollution.

(Source: National Environmental Engineering Research Institute)

Asthma can be defined as a chronic inflammatory disease of airways that is characterized by increased responsiveness of the tracheobronchial tree to a multiplicity of stimuli. Asthma attacks all age groups but often starts in childhood. In an individual asthma attacks may occur from hour to hour and day to day. In an attack, the lining of the passages swell causing the airways to narrow and reducing the flow of air in and out of the lungs.

Risk Factors

Asthma cannot be cured but could be controlled. The strongest risk factors for asthma are exposure, especially in
infancy, to indoor allergens and a family history of asthma or allergy. A study in the South Atlantic island of Tristan da cunha, where in 3 of the 300 inhabitants has asthma, found that children with asthmatic parents were much more likely to develop the condition. Exposure to tobacco smoke and exposure to chemical irritants in the workplace are other risk factors for developing asthma.

Urbanization appears to be correlated with an increase in asthma. Experts are struggling to understand why rate of asthma is rising world wide 50% every decade.

One such incident in London, U.K. in June 1994 saw 640 people rushed to emergency departments in the throes of full-blown asthma attacks. The World Health Organization recognizes asthma as a disease of major public health importance and plays an important role in the coordination of international efforts against the disease.

A series of cases have been reported showing a high incidence of emotional factors (Halliday, 1937., Mc Dermolt & Cobb, 1939), including some cases in which psychological stresses have been said to precede the appearance of the first attack of asthma.

Systematic studies of French and Alexander (1941), attempted to establish a specific psychological basis in asthma.
These investigators and their coworkers at the Chicago Psychoanalytic institute studied 27 patients who were suffering from both allergic asthma and emotional difficulties. They concluded that asthmatics show a specific psychogenic predisposing factor in the form of maternal over-dependency, with an exaggerated fear of losing maternal love & protection.

**Age:** Asthma and airways responsiveness are increased in very young and a very old individuals, individuals at the extremes of age have lower levels of lung function, such that milder degrees of airway inflammation and smaller changes in lung function may precipitate symptoms and hence, the diagnosis of Asthma.

**Gender:** Asthma in childhood is predominantly a male disease until puberty, following puberty asthma incidence is greater in females.

**Race:** Asthma prevalence is higher in blacks than in Whites.

**Socio-economic Status:** Lower socio-economic status is associated with an increase in asthma prevalence. This is due to indoor air pollution, maternal cigarette smoking, allergen exposure and decreased access to medical care.

**Young Maternal Age:** Some reports in literature suggest that infants born to mothers who are very young (i.e. less than 20 years) have an increased incidence of asthma.

**Prematurity** – Infants born prematurely carry a 4 fold increased
risk of development of asthma.

**Respiratory illness** – studies have demonstrated a prominent association between lower respiratory tract viral infections in early life and wheezing illness. Viruses are the precipitants of an even higher percentage of severe asthmatic exacerbation.

**Smoking:** Smoking has been associated with airway hyperresponsiveness in a number of population survey (Burney et al., 1987) as well as in many clinical studies. Smoking causes temporary increase in airway responsiveness in normal people. Several studies have reported a higher prevalence of asthma in children of smoking parents.

**Air Pollution:** Pollution could play an important role in asthma pollutant levels as a strong determinant of asthma (Department of Health, 1995b) Air pollution is unlikely to be the main driving force behind the recent increase in prevalence of asthma.

**Genetic Factors:** Asthma and allergy have long been recognized to have a familial basis. In a paper published in 1916, Cooke and Vanderveer studied family histories of 504 patients with allergy and concluded that inheritance is a definite factor in human sensitization.

**Psychological Factors:** A wide range of emotional situation may provoke asthma-anxiety, depression, guilt, anger, frustration, pleasure etc. Asthmatics are generally nervous and hyper-irritable.
Cattel's 16 PF personality profile studies and Rosenzweig picture frustration studies showed that asthmatics have suppressed aggression and guilt more than normals. Any unpalatable situation (emotional or psychological) may provoke an attack in them. According to Thomas Willis (1672) emotion could bring an attack of asthma. Rees found that when compare with a control group of surgical patients, asthmatics patients had a significantly higher prevalence of anxiety, timidity, sensitiveness and obsessional traits and neurotic symptoms. He found that the psychological status of the patients antedated the onset of asthma. Houston, Joiner, and Trounce (1966) have given the following statement: "Psychological influences play some important part in nearly every asthmatics and quite often they appear to be mainly responsible, if not in starting the asthma, atleast in maintaining it". Anxiety of various kinds, a sense of frustration, or frequency discord, and an atmosphere of tension in home, often underlie the tension in the bronchi. Treatment is not likely to be satisfactory unless these influences are appreciated and the patients handled with sympathetic understanding, tact and firmness, and the difficulties eased as much as possible.

In most recent studies adverse psychological factors have been found in between 60% and 86% of asthma deaths, and in 88% and 89% of those with near fatal asthma. Most of the patients have
experienced more than one adverse psychological and/or social factors like depression, psychiatric history in a first degree relative, social isolation, marital problem, smoking, unemployment etc.

CLASSIFICATION OF ASTHMA

1. **Persistent Asthma** A patient with symptoms of asthma whose airway function is abnormal between attacks. The abnormal function can often be reversed.

2. **Episodic Asthma** A patient whose airway function is normal between attacks. Episodic asthma is more common in children than adults, and occurs in patients who are allergic to pollens and grain dusts during the season of exposure.

3. **Occupational Asthma** Occupational asthma is uncommon, but it is important to recognize patients with this disease at an early stage, because it is potentially reversible. Usually, it is episodic at first, but becomes persistent.

Classification Of Asthma Severity

**Mild Asthma** Discrete attacks for no more than 1-2 days occurring no more often than one per month, with very brief attacks.

**Moderate Asthma** Attacks occurs more often than twice weekly with occasional more prolonged exacerbations and requiring frequent or daily medication for relief of symptoms.

**Severe Asthma** Continuous symptoms with occasional prolonged
severe exacerbation and required daily medication. Mild and moderate asthma may be seasonal. Severe asthma is rarely seasonal although the severity of symptoms and need for treatment may fluctuate from time to time.

There are two other forms of asthma which do not fit in above classification but are seen from time to time occurs in patients.

1. **Exercise Induced Asthma (EIA)** Exercise is a potent stimulus for a short attack of bronchospasm and occurs in most asthmatics if they exercise hard enough.

2. **Sudden life-threatening Asthma** A few asthmatics suffer from infrequent but devastatingly severe attacks of asthma often the onset of an attack is unpredictable.

**PREVALENCE:**

Asthma is a common disease with an overall prevalence in the general population on of 6-7 %. A higher prevalence of the disease is found in the elderly. It is estimated that 7-9% of the individuals over the age of 70 has asthma.

The prevalence of asthma and allergy continues to increase practically everywhere in the world. India has an estimated 15-20 million asthmatics.

The multi center European community respiratory health survey, in Mumbai interviewed 2313 adults about asthma symptom’s,
diagnosis, and medications they have taken in the previous 12 months in the second phase of the study, the researchers gathered more detailed information about smoking histories, housing characteristics, serum IgE levels, and results from skin tests with nine allergens. According to them, the asthma prevalence was 17% compared with 3.5% by physician diagnosis.

Another study was carried out on bank employees in 4 centres of Vellore town. The prevalence of self reported bronchial asthma was 8.3% that of asthma related symptoms 15.8%. There was a significant association between those who have symptoms of asthma and a positive family history of asthma.

Prevalence of asthma was calculated among adults in North India, using a Hindi adaptation of the International Union Against Tuberculosis and Lung Diseases (IUATLD) 1984 Questionnaire. True population prevalence calculated from the observed prevalence using specificity and sensitivity of the questionnaire was 3.94% in urban men, 3.99% in rural men, and 1.27% in both urban and rural women (Jindal et al, 2000).

According to new worldwide survey which covered 140,000 persons aged between 20 and 44 in European union countries and Iceland, Estonia, Switzerland, Algeria, India, Newzealand, Australia and the USA. The main cause of asthma was found to be due to environmental factor and allergens. The prevalence can
vary by a factor of 1 to 6 from one country to another.

The ECRHS is the first study to access the geographical variation of asthma and allergic diseases in a large number of countries. First they used identical standardized protocol for all the different areas.

Second they combined subjective and objective measurement, the good thing is that both approaches indicates the same, quite marked pattern of geographical variation in asthma and allergic diseases.

Asthma is not just a public health problem for developed countries. In developing countries, however, the incidence of the disease varies greatly.

- India has an estimated 15-20 million asthmatics.
- In the western pacific region of WHO, the incidence varies from over 50% among children in the caroline islands to virtually zero in Papua New Guinea.
- In India, rough estimates indicate a prevalence of between 10% to 15% in 5-11 year old children.

The human and Economic burden.

Mortality due to asthma is not comparable in size to the day-to-day effects of the disease. Although asthma is avoidable, but is found to occur in epidemics and affects young people.

- World wide, the economic costs associated with asthma are
estimated to exceed those of TB and HIV/AIDS combined.

- In the United States, for example, annual asthma care costs (direct & indirect) exceed US $6 billion.
- In Australia, annual direct and indirect medical costs associated with asthma reach almost US$460 million.

Janmeja (2002) said more than 150 million people in the world are suffering from asthma. In developed countries about 10% of the population has asthma. In India 2 to 5% population has this disease, while the incidence is around 10 to 15% in children.

**Hypertensive Heart Disease:**

In many developed, countries hypertension is the commonest cardiovascular problem and developing countries are also facing this problem. Hypertension is a disorder that is characterized by high blood pressure, generally this includes systolic blood pressure (the “top” number of your blood pressure measurement, which represents the pressure generated when the heart beats) consistently higher than 140, or diastolic blood pressure (The “bottom” number of your blood pressure measurements, which represent the pressure in the vessels when the heart is at rest) Consistently over 90.

Hypertension is an “iceberg” disease. It is a major public health problem in our society and the cause of countless cases of stroke, myocardial infarction, congestive heart failure, renal
failure and peripheral vascular disease. As the U.S. population ages, the incidence of hypertension increase as well, nearly 50% of people aged 65 and older have high blood pressure (i.e. systolic-140 mm Hg diastolic -90 mm Hg). Yet many of them are not aware of the problem.

The National Health and Nutrition Examination survey III conducted between 1991 and 1994, showed that only 68% of patients with Blood pressure values above 140/90, know they had hypertension, and only 55% were being treated. The patient at greatest risk for the consequences of high blood pressure are the elderly, many of whom have a form of hypertension known as isolated systolic hypertension.

**Classification of Hypertension**

Clinically, hypertensive individuals are characterized according to the severity of their illness on the basis of either diastolic or systolic blood pressure. The precise cut-off points are arbitrary and vary between different classification systems but generally WHO classification (1978) depends on diastolic blood pressure level.

1. Mild-diastolic pressure 95-110 mm Hg
2. Moderate 111-120 mm Hg
3. Severe 125 mm Hg.
Sixth joint National committee criteria (1997) Classification of blood pressure for adults 18 years and older-

<table>
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<th>Category</th>
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<th>Diastolic BP (mmHg)</th>
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<tr>
<td>Optimal</td>
<td>Less than 120</td>
<td>Less than 80</td>
</tr>
<tr>
<td>Normal</td>
<td>Less than 130</td>
<td>Less than 85</td>
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<tr>
<td>High normal</td>
<td>130 – 139</td>
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<tr>
<td>Stage 1 Hypertension</td>
<td>140 – 159</td>
<td>90 – 99</td>
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<td>Stage 2 Hypertension</td>
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</tr>
<tr>
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<td>180 – and above</td>
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Hypertension is generally divided into 2 broad groups.

1. **Primary or essential hypertension:** Hypertension is classified as “essential” when the causes are generally unknown. Essential hypertension is the most prevalent form of hypertension accounting for 90% of all cases of hypertension. Two third of all cases of essential hypertension are in the 45-60 age group.

In the 1950s and 1960s, an important debate occurred between the British Physicians over the influence of heredity on high blood pressure in humans. Robert Platt argued that essential hypertension was a “qualitative” disease, controlled by a single gene, with a biomedical population distribution. George Pickering thought that hypertension was a “quantitative” disease and was controlled by multiple genes in combination with environmental
influences. Today, both environmental and genetic factors are under intense study as possible etiologic factors at the individual level and the population level. Fortunately, however, successful efforts are being made to lower blood pressure through diet, stress reduction, exercise, weight control, and medication.

Causes of primary or essential hypertension are unknown but several factors seem to play a role that includes:

- Hyperactivity of sympathetic nervous system.
- Increased renin secretion.
- Expanded vascular volume.
- Excessive dietary intake of salt etc.

2. Secondary Hypertension

This accounts for less than 10-12% of all hypertension. It can occur at any age. Hypertension is classified “secondary” when some other diseases process or abnormality is involved in its causation (i) diseases of Kidney (Chronic glomerulnephritis and Chronic pyelonephritis and polyanystic disease, diabetic nephropathy, renal artery stenosis (ii) endocrinal diseases, cushings syndrome, tumours of adrenal glands (iii) cardiovascular diseases-congenital narrowing of aorta (iv) miscellaneous-toxemias of pregnancy, drugs, oral contraceptives containing destroying anabolic steroids, NSAID, Corticosteriod
carbenoxolone. According to clinical course both essential and secondary hypertension may be: (i) Benign and (ii) Malignant

(i) **Benign hypertension**: About 90-95% patients are benign hypertensive. It has moderate elevation of blood pressure which rises slowly as the years pass.

(ii) **Malignant hypertension**: Less than 50% hypertensive patients develop malignant hypertension. Malignant hypertension is marked with rapid increase of blood pressure to 200/140 mm Hg and has serious damaging effect.

Patient who have occasional blood pressure readings of over 150/90 mm Hg may very well be in an early phase of essential hypertension (Levy et al, 1944).

**Risk Factors:**

Hypertension is not only one of the major risk factors for most forms of cardiovascular diseases, but it is a condition with its own risk factors. A WHO scientific group has recently reviewed the risk factor for essential hypertension. These may be classified as:

**Non Modifiable Risk factors:**

(a) **Age**: Blood pressure rises with age in both sexes and the rise is greater in those with higher initial blood pressure. Age probably represents an accumulation of environmental influences and the effect of genetically programmed senescence in body systems.
(b) Genetic Factors: There is considerable evidence that blood pressure levels are determined in part by genetic factor. The evidence is based on twin and family studies. Twin studies have confirmed the importance of genetic factor in hypertension. Family studies have shown that the children of two normotensive parents have 3% possibility of developing hypertension, whereas this possibilities is 45% in children of two hypertensive parents. Blood pressure levels among first-degree adult relatives have also been noted to be statistically significant. Heredity plays an important role in cardiovascular illness, was suggested by Day and Day (1972). It has been observed that 40% issues are affected when both father and mother have hypertension whereas only 30% are affected while one of them is hypertensive.

Modifiable Risk Factors:

a) Obesity: Epidemiological observations have identified obesity as a risk factor for hypertension. The greater the weight gain, the greater the risk of blood pressure. Gupta et al., (1977) observed that with the increasing weight there is progressive rise in blood pressure.

b) Salt Intake: There is an evidence that a high salt intake (i.e; 7-8g per day) increases blood pressure. Low sodium intake has been found to lower blood pressure. For instance, higher incidence of hypertension is found in Japan where sodium intake is very high.
c) Alcohol: High alcohol intake is associated with an increased risk of high blood pressure. Habit of cigarette smoking affects human longevity adversely by several ways- notably by causing increase morbidity and mortality.

d) Environmental Stress: The term hypertension itself implies a disorder initiated by tension or stress. It is an accepted fact that psychosocial factors operate through mental processes, consciously or unconsciously produce hypertension. Mathur et al (1963) and Celine (1970) found highest mean systolic and disystolic blood pressure in higher socio economics groups and lowest in low socio economic groups

Others Factors: Recent evidence suggests that saturated fat raises blood pressure as well as serum cholesterol. The commonest present cause of secondary hypertension is oral contraception, because of oestrogen component in combined preparations. Other factors such as noise, vibration, temperature and humidity require further investigation.

PREVALENCE

High blood pressure is a major contributor to the India’s populations morbidity mortality and related cardiovascular diseases-stroke and renal insufficiency with the globalization and lifestyle changes that are now taking place in the region. Around 10-15% of the adult population is already affected by hypertension
in India.

The prevalence of hypertension dependence on both the racial composition of the population studies and the criteria used to define the condition. In white suburban population like in the Framingham study nearly one fifth of the individuals have blood pressure $>160/95$ while almost one half have blood pressure $>140/190$.

An even higher prevalence has been documented in the non-white population. In female the prevalence is closely related to age, with a substantial increase during after age 50. The increase is presumably related to hormonal changes of menopause, although the mechanism is unclear. The ratio of hypertension frequency in women Vs men increases from 0.6 to 0.7 at age 30 to 1.1 to 1.2 at age 65. The prevalence of various forms of secondary hypertension depends on the nature of the population studied and how extensive the evaluation is.

According to meta analysis the prevalence of hypertension among adults in India is 11%. There is an increasing trend in the prevalence of hypertension.

The incidence is more in urban than in rural population. In Karanatka hypertension was observed 1% among boys and 0.6% among girls. The prevalence of hypertension was 59.9 and 69.9 per 1000 in males and females respectively in the urban population
and 35.5 and 35.9 per 1000 in males and females respectively in the rural population (Gupta, 1997)

High blood pressure ranges from 4.3 to 12.1%. In a survey in progress in urban Delhi, a prevalence of 17.4% has been observed in person, aged 35-64 years (Using a threshold of 140/90 mm Hg) (Source-WHO, World Health Statistics Quarterly, 1993) Aggarwal (1992) observed a prevalence of hypertension as 37.8% in cardiovascular diseases cases in a study conducted in Jawan Block of District Aligarh.

A higher prevalence of hypertension in males was noticed by Chadha (1991) Aggrawal (1992), and Joshi et al., (1993), Goel and Kaur (1995) and Sharma and Singh (1997) observed a higher prevalence of hypertension in females.

It is well recognized that hypertension is now a major health problem in India. The various epidemiological studies published from India over the last decades are presented in a graphical form in fig 1 A review of this data shows that prevalence of hypertension has progressively increased over the last 5 decades, particularly in the urban areas the studies are not representative of the total Indian population, as these have been limited to singly centers. The fact that hypertension is a major health problem in our country calls for large, nationwide, multicentric, prospective and supervised epidemiological studies.
Fig. 1: Prevalence of Hypertension in India

Source: Pfizer India: Indian Guidelines for Management of Hypertension
Singh (2002) said that according to a PGI study about 6 to 25% Punjabis are suffering from hypertension.

**Hypertension: A Burgeoning Burden in Poor Countries:**

By 2025 most elderly in the world will be living in developing countries, hypertension is one of the commonest diseases of the elderly, likely to pose a considerable burden on these countries. There were 600 million hypertensive in the world at risk for heart attack, stroke and cardiac failure, 180 million in the high income and 420 in the low middle-income countries.

A cross sectional community based survey, undertaken by the hypertension study group to determine the prevalence of hypertension among the elderly at two cities in Bangladesh and three in India, found that 65% of the 1203 elderly individuals surveyed had hypertension and only 45% were aware of the fact. Of the 40% hypertensive taken medication, only 10% were receiving adequate treatment. Hypertensive heart diseases are the leading cause of illness and death from hypertension. It affects approximately 7 out of 1000 people. 30 million people die annually from hypertension and other heart conditions.

The main aim of the present study is to examine the influence of religiosity, ego-strength, and social support on subjective well-being of the bronchial asthma and hypertensive patients. A brief account of each variables is given in the
SUBJECTIVE WELL-BEING

The term "subjective well being" (SWB) refers to people’s evaluations of their lives. These evaluations include both cognitive judgments of life satisfaction and affective evaluations of moods and emotions. If a person reports that her life is satisfying, that she is experiencing frequent pleasant affect and that she is infrequently experiencing unpleasant affect, she is said to have high subjective well-being. Although life satisfaction, pleasant affect, and the lack of unpleasant affect often co-occur to some degree within the same individuals, these components are separable. Someone who experiences a great deal of pleasant affect, for example, may also experience very little unpleasant affect and be labeled “happy”, whereas someone who experiences high level of both pleasant and unpleasant affect may be labeled “highly emotional.”

Subjective well-being especially life satisfaction is likely to reflect the person’s fulfillment of his or her values and goals, and involves the search for meaningfulness in one’s life. SWB becomes a broader measure of quality of life because it reflects deeper values beyond physical pleasure and ephemeral emotions.

Personality traits influence levels of subjective well being.
For example, Costa (1994) reviews evidence that even over a period as long as 30 years, adults are stable in their personalities. If biologically based personality predispositions influence SWB, we expect similar stability over time for SWB. In a longitudinal study, Magnus and Diener (1991) found that life satisfaction correlated .58 with the same measure administered four years later. Even when life satisfaction at time 1 was self-reported and at the other time was reported by the family and friends of the respondent, the correlation over four years was .52. The use of two measurement sources is important in demonstrating that the stability of SWB is not simply an artifact or consistent response such as acquiescence or social desirability. The high correlations between self-report and informant report ratings of life-satisfaction, even over long time intervals, suggest that the basis for life satisfaction judgments is not only consistently used, but is substantive enough to be recognized by and communicated to friends and family members.

The affective components of SWB (pleasant and unpleasant affect) also exhibit stability across time. Watson and Walker (1996) found that trait affect scales showed a moderate level of temporal stability when assessed over a six year interval and Costa and MacCrae (1988) found that there were significant stability coefficients.
(in the 50 range) between spouses ratings of one's emotion at time 1 and the target person's self rating six years later.

Evaluations of one's life, whether affective or cognitive, do not result from a purely "bottom up" process. People do not simply weigh the effects of various external circumstances to arrive at SWB judgments, because happiness remains moderately stable in spite of changing circumstances and changing environments. In fact, evaluations of specific events and domains in one's life are colored by his/her overall happiness. Kozma (1996) reported that when respondents were asked to rate their satisfaction with various domains in their lives (e.g., work, home, relationships), these satisfaction judgements were correlated. If overall happiness was controlled, however, correlations among the different domains were no longer significant. These data suggest a top-down model in which a trait like construct of overall happiness influences feelings about specific domains. Thus, satisfaction with specific life domains likely is due to specific factors in that domain as well as substantial influence from the person's general level of SWB.

Although traits such as self-esteem and optimism are not primarily affective in nature, there is reason to believe that they would influence or be influenced by well-being. Self esteem theorists, for example, hypothesize that positive evaluations of the
self are necessary for positive overall well-being. Lucas, Diener, and Suh (1996) showed that self-esteem and optimism do in fact correlate with measures of SWB such as life satisfaction, pleasant affect, and unpleasant affect.

Proponents of the temperament model (e.g., Eysenck, 1967, Gray, 1981, Larsen and Ketelaar, 1991; Headey and Wearing, 1989) postulate a biological determinant of SWB. Headey and Wearing, for example, suggest that a person's baseline level of happiness is decided by his or her temperament.

The general tendency toward positive thoughts would explain why the majority of people report positive levels of SWB (Diener and Diener, 1996). Perhaps more importantly for the current topic, individual differences exist in pollyannaism. Those who are able to recall more pleasant stimuli are also more likely to report that they are happy. It is possible that differences in accuracy and efficiency of processing pleasant information versus unpleasant information may lead to differential levels of well-being.

According to Lyubomirsky and Ross (1996), the happy person's world is one of attractive possibilities, whereas the unhappy person's world is "a place where one has been obliged to choose not between better and best, or even between good and better but rather between mediocre and bad or even between bad
and worse.” *(in press, p.28)*. The ability to focus on positive information may provide a cognitive strategy to increase well-being, and individual differences in this ability may influence well-being. People with high SWB are those who have developed effective strategies. For meeting their needs within the constraints of cultural expectations and life circumstances.

Personality is often the strongest predictor of SWB. Extraversion and neuroticism as well as narrower traits (e.g., self esteem and optimism) are consistently related to various cognitive and affective forms of SWB. These relations are particularly strong when the data are controlled for measurement error. The presence and characteristics of the goals that individuals work for in their lives are also related to well-being.

Subjective well-being reflects a stable and consistent phenomenon that is theoretically and empirically related to personality constructs.

There are three primary components of subjective well-being: satisfaction, pleasant affect, and low levels of unpleasant affect. Each of the three major facets of subjective well-being can broken into sub-divisions. Global satisfaction can be divided into satisfaction with the various domains of life such as recreation, love, marriage, friendship, and these domains can be divided into facets. Pleasant affect can be divided into specific emotions such
as joy, affection, and pride. Finally, unpleasant or unpleasant affect can be separated into specific emotions and moods such as shame, guilt, sadness, anger and anxiety. Subjective-well being can be assessed at the most global level, or at progressively narrower levels, depending on one's purposes. There is a tendency for people to experience similar levels of well-being across different aspects of their lives.

Cognitive theories of well-being and ill being within the behavioral sciences were developed in the last decades. For example, the attributional theory of depression is well-known. Depressed individuals are more likely to believe that negative events are caused by global and stable causes, such that negative are very likely to continue to happen to them. Beck (1967) popularized the idea that depressed people think about the world in self-defeating ways. In the area of subjective well-being, researchers find that one can dampen or amplify one's emotions by what one thinks, and thereby experience more or less intense emotions (Larsen, Diener, & Cropanzano, 1987). Happy people are likely to experience more events that are considered desirable in the culture, but also have a propensity to interpret and recall ambiguous events as good. (Lyubomirsky & Ross, 1996, Seidlitz & Diener, 1993) People with high subjective well-being may not only experience objectively more positive events, but they also seen to
perceive events more positively than do people who are low in SWB.

Measures of subjective well being show moderate to high temporal reliability for example life satisfaction correlates .58 over a four year period, and this correlation remains strong (.52) when informant reports of life satisfaction are substituted at the second testing (Magnus, Diener, Fujita & Pavot, 1993). In addition pleasant affect and unpleasant affect have a degree of stability across a period of many years (e.g., Costa & MC Crae, 1988; Heady & wearing, 1992).

These findings suggest that SWB does change, but that there is some constancy in it even over a prolonged period.

Theories of coping are based on the idea that in order to cope with problems happy people initiate thoughts and behaviours that are adaptive and helpful, where as unhappy people cope in more destructive ways.

Temperament has a powerful effect on SWB studies of heritability in which twins separated at birth are studied as adults found that both pleasant and unpleasant affect have a strong genetic basis (Lykken & Tellegen, 1996; Tellegen, Lykken, Bouchard, Wilcox, Segal & Rich, 1988). Lykken and Tellegen estimated that 80 percent of the variability in long term negative affect is due to inherited characteristics. Although heritability
coefficients may differ in other environments, the twin data show convincingly that some proportion of SWB is due to one's genetic make up.

**Context theories**

Some theorists such as Veenhoven (1991) maintain that SWB is caused by the satisfaction of basic, universal human needs. Context theories emphasize that the factors that influence SWB are variable across both time and individuals, and that how good or bad life events are considered to be is based on the circumstances in which people live. The relevant context varies in different theories. In adaptation theory, for example, the relevant context is the person's past life, whereas in social comparison models the context is considered to be social others of whom the target individual is aware. Other contexts that could influence SWB are the persons ideals, and imaging counter factual alternative situations.

**Telic theories**

This group of theorists explains that SWB is gained when goals and needs are reached (Diener 1984) Brunstein(1993) further found that a higher level of commitment, along with a sense of progress, contributed to higher SWB.

According to this theory, the extent that people have different goals, the causes of SWB ought to differ. For example,
the exact resources (e.g., money and social skills) the most strongly practiced SWB for an individual are likely to be those that are required to gain his/her specific aims. (Diener & Fujita, 1995).

Mc Adams and Vaillant (1982) observed that individuals high in intimacy motives exhibited higher overall psychological adjustment.

Health is positively related to well-being. Self reports of health reflect one's level of emotional adjustment as well as one's objective physical health or condition (Hooker & Siegler, 1992; Watson & Pennebaker 1989), and the relation between health and emotional well-being is artificially inflated by this emotional component.

It has been hypothesized that a person's level of subjective well-being is in part determined by comparisons he or she makes with standards (Michalos, 1985). Often people's standards come from observing people around them or remembering what they themselves, were like in the past. It is hypothesized that if people exceed these standards, they will be happy and satisfied, but if they fall short of their standards, they will experience low levels of emotional well-being (e.g., Michalos, 1985).

People might increase their subjective well-being by the control of their thoughts. For example, subjective well-being can
be increased by believing in a larger meaning or Force in the universe. Support for this proposition comes from findings showing that on average religious people are happier than non-religious people (e.g. Ellison, 1991; Myers, 1992, Pollner, 1989). Further, SWB is higher if a person concentrates on attainable goals, and does not focus attention exclusively on distinct, difficult goals (Emmons, 1986, 1992). Finally, one can heighten subjective well-being by being optimistic about one’s future. (Scheier & Carver, 1993)

Religiosity

Various fields of scientific psychology like more applied areas of clinical, counseling, health and rehabilitative Psychology, are becoming aware of and impressed by the religious concerns in people’s life. Religion and spirituality are an integral part of human culture, and have the potential to shape individual lives and personalities.

Belief in God is a universal (although controversial) attitude that has existed almost as long as man and his myriad fears and anxieties. Belief in God is closely linked to the concept of religiosity. The word religiosity has emerged from the broad concept of religion, which may be said to be the recognition that all things are manifestations of a power which transcends our knowledge.
Philosophers and Psychologists, both agree that belief in God fulfills a psychological need which in the words of Galloway (1925) becomes more intense in situations of insecurity, fear, inadequacy and mental illness wherein the unsatisfied individual sees the faith in Almighty as satisfying a need in himself. The universality of a felt need is the secret of the universality of religion. For a psychologist like Erikson religion is an aspect of human life, which is to be accepted. According to him religion is the phenomenon which is translated into significant words, images, and codes both the exceeding darkness that surrounds man’s existence, and also the light which pervades, which apparently is beyond all comprehension. Erikson (1965) feels that certain factors like basic trust as well as the internalization of the creator-creation relationship are essential for human development and hence for religious development too. As a psychologist Erikson feels that young people need an ideology for their sense of identity in the form of unconscious tendency which underlies religious, scientific and potential thinking, binding together facts and ideas in such a way that a world image comes into being which supports the collective and the individual sense of identity i.e. the consciousness. One might be able to say “this is what I am and this is where I stand”.
For Sigmund Freud the value of religion for man consists solely in the importance which religious ideas have to him. He starts from the notion that the life on Earth is a burden. On Earth he is a helpless being and because of helplessness, he is in need of a father or God. Belief in God, therefore, springs from fear. Religion has to solve the riddle of the universe and to reconcile man to suffering and is marked by the tension between the pleasure principle and the reality principle with fear and sense of guilt as its concomitants. The positive aspect of the religion according to him is sublimation which in its comfortable form is one of the fortunate things of being able to come close to God.

According to Tillich (1951) religion can be seen as exploratory behaviour, driven among other things by man's curiosity and by his perpetual attempts to maximize contact with a maximal environment, to the full deployment of his potentialities. Broadly speaking, religious life may be divided into three phases faith, thought and discovery. In the first phase religious life appears as a form of discipline, which the individual on the whole must accept as an unconditional command with any rational understanding of ultimate meaning and purpose of that command. Perfect submission to discipline is followed by a rational understanding of the discipline and the period religious life seeks its foundation in a kind of metaphysics, a logically consistent view of the world.
with God as a part of that view. In the third phase metaphysics is
disciplined by psychology and religious life develops the ambition
to come into direct contact with the reality. It is here that religion
becomes a matter of personal assimilation of life and power, and
the individual achieves a free personality, not by releasing himself
from the fathers of the law, but by the ultimate sources of the law
within the depths of his own consciousness.

The climax of religious life, however, is the discovery of the
ego as an individual deeper than has conceptually describable
habitual self hood. It is in contact with the most real that the ego
discovers its uniqueness, its metaphysical status, and the
possibility of improvement in that status. It seems that the
methods of dealing with reality by means of concepts is not at all
a serious way of dealing with it. Religion, which is essentially a
mode of actual living, is not only serious way of handling reality.
For those involved, religion is its another sphere of human quest
and fulfillment, like relationships and work or like health or
happiness, those not involved may see it in a more negative way.
Watts and Williams (1988) have recently tried to provide a
psychological model for religious knowledge. They suggest that it
is like the insights and understanding achieved by a patient in
psychotherapy. This is an intuitive, partly emotional process,
rather than a rational one and is achieved by great effort. There is
a Complex relationship between mind, body and spirit. In a analysis of 42 different clinical studies, MC Cullough (1998) found that religious involvement was associated with lower death rate, even after accounting for obvious health advantages such as less alcohol and tobacco use and more social support.

According to a recent news week poll, 84% of Adult Americans say they believe God performs miracles, and 48 percent reported that they have experienced or witnessed one. In the Quran, the prophet Mohammed is instructed to reject requests to work miracles, as the Quran itself is the only miracle a Muslim needs. Islam means submission to Allah; Sufi mystics who submit their minds and bodies in total prayer achieve a level of spiritual knowledge that produces Karamat (wonders). Miracles are found in all five of the world’s major religions.

The notion that religious faith can promote Physical well being is not new. Most of us have heard of cases in which someone, seemingly by sheer faith and will, has miraculously recovered from a terminal illness or survived for longer than doctors thought possible. What is new is that such rewards of religion are becoming the stuff of science. We can not prove scientifically that God heals, but I believe we can prove that belief in God has a beneficial effect”, declares Dr. Dale A. Matthews, a medical professor. “ There a little doubt that healthy religious
faith and practices can help people get better”.

More than 30 studies have found a connection between spiritual or religious commitment and longer life. Among the most compelling:

* A survey of 5286 Californians found that church members have lower death rates than non members regardless of risk factors such as smoking, drinking, obesity and inactivity.

* People with a strong religious commitment seem to be less prone to depression, suicide, alcoholism and other addictions, according to one research analysis.

Praying evokes beneficial changes in the body. When people pray, they experience some decrease in blood pressure, metabolism, heart and breathing rates as the famous “relaxation response” described by Dr. Herbert Benson of the Harvard Medical School. Patients also agree that prayer is a powerful tool in healing. Polls by TIME/CNN and USA weekend show that about 80 percent of Americans believe spiritual faith or prayer can help people recover from illness or injury.

“Religiousness is not a philosophy or a theology. It is like love.... The highest, most refined quality of love. You love one person-Religiousness is falling in love with the whole existence.” (says Ocho, The Zen Master)

Religious faith leads into a unquestionable belief in a
transcendental reality which is regarded as the ultimate. The incomparable spiritual power of Prophets posthumously influencing billions of people centuries and throughout the development of civilization has its roots in faith. Faith, is therefore, a tremendous power in itself 'Almost all religions based on faith support man's aspiration for the continuation of his identity and existence after death. Rabbi Rachel Cowan, Director of The Jewish Life Program, explained a physiologically adaptive basis for religion, she says, "(religious) rituals gives you a bearing in time and space. It connects you with a source of hope. She further stated "healing does not mean curing. You live in deep emotional and beautiful spiritual discovery, and it makes you feel authentically loved." It changes the experience of illness.

In a study of 91,909 individuals in Maryland, those who attend church once or per week had:

- 50% fewer deaths from coronary artery disease
- 56% fewer deaths from emphysema
- 74% fewer deaths from cirrhosis
- 53% fewer suicides

Religion seemed to help in recovery. Patients with higher intrinsic (inner) religiosity scores had more rapid remissions than patients with lower scores. The researches found that religious faith may provide patients with a sense of hope that things will
turn out all right regardless of their problems and thus, foster greater motivation to achieve emotional recovery.

Psychiatrist Dariel Larson, who specializes in studying the effects of religion on physical health and mental health found that people, who have faith consistently exhibited higher levels of mental, physical and relational wellness. Larson found that “In the area of Psychiatry, 92% of the finding showed that religious commitment produced some kind of beneficial effect”. Larson and his colleagues found that in almost every instance, religious people lived longer than non religious people even when into account “other risk factors such as weight, age and smoking.”

In 1987 researchers of University of Texas “Carefully examined 27 studies on church attendance and health”. Their analysis revealed that in all but seven studies. “Frequent Church attenders were healthier as a group than less frequent attenders.” David Larson, in a study of men’s blood pressure, found that “even smokers benefited from religion”. Larson found that smokers who were not religious “were seven time more likely to have abnormal blood pressure than those who said religion was important”.

Recent studies revealed that “religious people seems to be better of psychologically than non religious people.” According to a study conducted at the University of Akron in Ohio, “people who
spent more time absorbed in prayer have a greater sense of well-being than people who did not pray or prayed very little. “Other studies suggest that religion helps people ward off the more serious Psychological effects of stress.” A recent study reveal that regular church attenders had fewer psychological disorder over time than non-attenders despite reporting same level of life stress.”

At present there is presence of spiritual and religious belief in Medical practice. JAMA created a medicine and religion department and has since periodically published review article on medicine and religion most of the research suggest that an active religious commitment is “beneficial for preventing mental and physical illness, improving recovery and enhancing the ability to cope with illness. Religion may promote help by adding social or psychological support (or both) to people’s lives. Religion can also improves the quality of life by enhancing patients subjective well-being, social support and stress and coping strategies, by providing systems of meaning and existential coherence by establishing personal relationship with one’s deity, and by ensuring social support and integration with in community.

In the “Two versions of Man” (1960), which was presented at one of the first star island conferences on science and religion, Murray argued for a new definition of religion, compatible with
science, that would be a center of gravity that attracts, binds and unifies the peoples of the free worlds. “Personality psychologist are said to provide glimpses of what its like to be human” (Carver, 1996). Religious goals, belief and practices are not only a distinctive component of a person, for many they are the core of personality. Many researchers have demonstrated the beneficial impact of religious faith and practices on psychological, physical and interpersonal functioning (Benson, 1996 Koenig, 1998; Matthews & Clark, 1998; Paloutzian & Kirpatrick, 1995; Pargament, 1997, Richards & Bergin, 1997; Shafranske, 1996). The “faith factor” emerges as a significant correlate of mental health indices of life satisfaction, happiness, self-esteem, hope and optimism, and meaning in life.

According to data recently published by the Princeton Religious Research Centre, the percentage of American who belief that the influence of the religion is increasing its influence (For better or worse) in society is now the highest it has been in 12 years. (“Dramatic Rise seen”, 1998)

Some research suggest that religious involvement is favourable associated with measures of physical health such as high blood pressure (Levin & Venderpool, 1989), Cancer (Jarvis & Northcott; 1987), heart diseases (Fried Lander, Kark, and Stein, 1986), Stroke (colantonio, Kasal & Ostfield, 1992), and suicide
(Kark, Shemi et al., 1996). Other studies suggest that religious involvement help to buffer the impact of stress on physical and mental health (Kendler, Gardner, & Prescott, 1997, Krause & VanTran, 1987, Pressman, Lyons, Larson, & Strain, 1990). Some data suggest that the association of religious involvement with mortality might be stronger in women than in men (House, Robbins, & Metzner, 1982, Strawbridge et al., 1997).

**EGO STRENGTH**

Freud (1924) used the construct of ego but did not expound upon it rigorously until the publication of Das Ich and Das ES in 1923 (Freud, 1927). Freud tells us that “the ego has the task of bringing the influence of the external world to bear upon the id and its tendencies, and endeavours to substitute the reality principle. The reality principle for the pleasure principle which reigns supreme in the Id... the testing of reality is rather one of the functions of the ego.” (Freud, 1927, p.30). According to Hinsie and Campbell (1963), the ego is “A part of the physic apparatus which is the mediator between the person and the reality, the perception of reality and adaptation to it.”

Symonds (1949), a leading psychoanalyst, maintains that the term ego is “used to refer to that phase of personality which determines adjustment to the outside world in the interest of satisfying inner needs.” This concept of ego has, however, been
modified by some recent ego-psychologists, who view ego as having a source of energy of its own, and as taking pleasure not only in the gratification of id impulses, but also in the mastry of the environment (Pervin, 1970, p.228).

Cattle (1949) has considered ego-strength as one of the factors of personality which is commonly known as “Ego-weakness vs. Higher ego strength” and it refers to the ability of a person to maintain ego and adjustment. Barron (1953) conceptualization of ego-strength, derived from the ego-strength scale item content and personality and intelligence test correlate involves physiological stability and health of personal adequacy and vitality, permissive morality, lack of ethnic prejudice, emotional outgoingness and spontaneity and intelligence.

To Pederson (1965) ego strength is a person’s ability to deal with reality. He observed that subjects with high ego-strength will have greater unconscious concern for achievement than subjects with low ego-strength.

Ego-strength can be defined as the total psychic energy at the disposal of the individual enabling him to enjoy his strivings to master the environment. It is not the amount of troubles, conflicts, and crisis that a person encounters but the manner and confidence with which he encounters them. Ego-strength is an important factor determining the capacity of an individual to
perceive a challenging situation realistically, to decide the course of action rationally, and to execute the response effectively. Barron, in creativity and personal freedom (1968), while dealing with ego-strength, maintains that the most important consideration in judging the strength of a person's ego is not the amount of troubles, conflicts, and crisis he encounters but the manner and confidence with which he encounters them. The capacity to meet the problems and challenges of life without being dismayed, and to endure suffering without foundering are the marks of ego-strength. An important aspect of ego-strength according to McClelland (1951), is the accuracy of the individuals self-picture. An accurate self-picture should include all the significant self-related perceptions even if they are consistent and unfavourable.

SOCIAL SUPPORT:

Man is a social animal and the ordinary healthy human being finds prolonged isolation a severe punishment. We have all heard a song “No man person is an Island”. The importance of closeness with spouse, with friends or with family members is taken for the prediction of healthy functioning (Berkman & syme, 1979) Jacobs & charles, 1980; Medalie & Gold bourt 1976; Thomas & Duszynki 1974). Literature on social support also suggests that it is an important concern in our daily lives social interaction with family and friends is an integral element of mental and physical health.
Lack of social support has been associated with risks for emotional problems, excessive worry, self preoccupation and stress proneness (Blazer, 1982, House et al., 1982) The concept of social support has variously been defined by the researchers as social bonds (Henderson, 1977), social networks (Mueller, 1987) meaningful social contact (Cassel, 1976), availability of social confidents (Brown et al., 1975) and human companionship (Lynch 1977); Cohen & syme (1985), and House & Kahn (1985) called social networks as structural support, structural support refers to the existence of an inner-connection between social ties (e.g. marital status, close family and friends) participation in group activities and religious group activities. It is an important predictor of healthy psychological and physiological functioning.

Social support which means turning to other people for support in times of personal crises, is one of the most often used coping strategies. Social support refers to the perceived comfort caring, esteem or help a person receives from other people or groups. Cabb, 1976, Gentry & Kobasa, 1984, Wallston et al., 1983; Wills, 1984. According to Cobb (1976) people with social support believe they are loved and cared for, esteemed and valued and part of a social network, such as family community organization, that can provide goods, services and mutual defenses at times of need or danger.
Health Psychologists have extensively studied the association between social support and mental and physical health and found it is extremely beneficial in highly stressful situations. There are different forms of social support. One type is practical support, which includes rides to the doctors office or help around the house. The next type is emotional support which refers to reassurance, trust and dependence. The final form of social support is appraisal support, such as help in figuring out what is happening and how to cope with it.

Health psychologists have found that family relationships play an important role for the patient's adaptation to the serious illness. The family seems to be the vital source in the overall adjustment.

If support is nonexistent for the patient, then they may respond negatively to their illness and keep their illness or problems hidden, which causes more stress for themselves. Kahn (1979); Kahn and Autonucci, (1980) define social support - as the expression of liking, admiration, respect, love agreement and affirmation as well as the provision of direct aid and assistance. It is apparent that social support is multidimensional construct, which not only represents that the person has social relationship but also indicates that he is esteemed and cared for. As a product of social activities or transactions he perceives that a
support can come from many different sources, the person’s spouse or lover, family, friends or community organizations, etc.

Another aspect of social support is the kind of help person receives from other i.e. emotional, personal, practical, informational, and instrumental. According to Caplan’s theory (1974), social support implies enduring pattern of continuous or intermittent ties that play a significant role in maintaining the psychological and physical integrity of the individual over time. For Caplan a social network provides a person with “Psychosocial supplies for the maintenance of mutual and emotional health”. According to Shumaker and Brownell (1984) supportive behaviour would be seem as an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of recipient. These interactions tend to be viewed as supportive when they are intended to gratify people’s need (Thoits, 1983).

Social support: Health and well-being.

Researches have proposed two theories the “buffering” and the direct “effects” hypothesis to explain the influence of social support on health and well-being. Studies have found evidence consisted with both theories (Cohen & Wills, 1985; Thoits, 1982; Wortman & Dunkel-Schetter, 1987)
Buffering Hypothesis

According to this hypothesis, social support affects health by protecting the person against those negatives effects of high stress. This hypothesis states that protective function is effective only when the person encounters a strong stressor under low stress conditions, little or no buffering occurs. Cohen and Wills (1985) suggested that there are at least two ways of the buffering process. One way involves the process of cognitive appraisal. When people encounter a strong stressor, such as a major financial crisis, those individuals with high levels of social support may be less likely to appraise the situation as stressful than those with low levels of support. Individuals with high social support may expect that someone they know can and will help, such as by providing the needed money or going advice on how to get it. As a result they judge that they can meet the demands and decide that the situation is not very stressful. Social support can buffer the effects of stress by modifying people's response to a stressor after they have appraised the situation as stressful. For example, people with high social support might have someone to provide a solution to the problem, convince them that the problem is not very important, or cheer them on to 'look on the bright side or count their blessing". People with little social support are much less likely to have any
of these advantages so the negative impact of the stress is greater for them than those with high levels of support.

**Direct Effects Hypothesis**

This hypothesis maintains that social support is beneficial to health and well-being regardless of the amount of stress people experience. According to this hypothesis, the beneficial effects of social support are similar under high and low stressor intensities. There are several ways by which direct effects may work (Cohen & Wills, 1985; Worthman & Dunkel Schetter, 1987). For instance, people with high levels of social support may have a greater sense of belongingness and self-esteem than those with little support. The positive effects of this hypothesis could be beneficial to health independently of stress experiences, such as making individuals more resistant to infection. High levels of support may also encourage people to lead more healthful lifestyles than low social support does. People with social support may feel, for example, that because others care about them and need them, they should exercise, eat well, and seek medical attention before a problem becomes serious.

Observation in a variety of settings have led to the idea that social support:-

a) Contributes to positive adjustment and personal development and increased well-being in general (Branda et al, 1980; Cohen &
Wills, 1985) and (b) provides a buffer against the psychological consequences of exposure to stressful life events. (Cohen & Syme, 1985; Cohen & Wills, 1985; Kessler & Mcleod, 1985).

Unden (1994) studied social support at work and its impact on health. Social support had a predominantly linear relationship with heart rate; subject with the least social support had the highest heart rate.

Researchers in the area of social support have found common themes related to the perception of outcomes of interaction between people. In this view there are five outcomes constituting social support (i) the perception of a positive emotion towards oneself from another, (ii) having one person agree with one's beliefs or feelings, (iii) encouragement by another person to express one's beliefs or feelings in a non threatening environment, (iv) the receipt if needed good or services and (v) confirmation that others will be there to when needed. The perception of social support services, an important function, is maintaining a positive sense of well-being by enabling one to cope with and adapt to stress. It has been shown to have a positive effect on physical as well as on mental health.

Social support can influence our health by making us less likely to experience negative emotions (Cohen & Herbert, 1996; Cohen 1988). Given the well established link between Chronic
negative emotions and poor health, a strong social support network can promote positive mood and emotions, enhance self-esteem and increases feelings of personal control. (Rodin & salovey, 1989).

Relationships are the basis of social support one of the main sources of happiness and of mental and physical health. Berkman and Syme(1979) found that the presence of intimate ties with friends and relatives were strongly related to low mortality rates and people who lacked community ties had considerably higher death rates than people with extensive social contacts. However, they also found that deficits in family’s friendship ties were more strongly related to mortality than were deficits in more general community ties. Implicit in such findings was the idea that intimate type of relationship (such as with friends & family) were the greatest sources of support.

Older people who lack social support may be at increased risk of heart disease, new researches shows. People low in social support, diastolic blood pressure averaged about 63 for young people, 74 for older people. In individuals with strong social support, the average for young participants was 67, for older ones 68.

Number of studies showed that low levels of social support and of participation in social network are related to increase risk of CHD. This has led to two hypotheses: either social isolation is
in itself a stress that increases the risk of disease, or social support acts as a buffer that helps people to cope with other stressful circumstances (Pestonjee, 1999), (Mohan 2000).

Need of the present study:

1) Psychosocial assessment of hypertension and bronchial asthma patients is well studied in the fields of clinical and health psychology. By and large results indicates that cardiovascular disorder patients (i.e. hypertensive) and respiratory disorder patients (i.e bronchial asthma) are exposed to various psychosocial problems. It is therefore needed to allievate these problems of the patients so that they are able to attian a healthy lifestyle.

The present study is an attempt to know the various psychosocial aspects of bronchial asthma and hypertensive patients and the effect of these aspects on their well-being.

Little research has been done to assess the impact of various Psychosocial factor like religiosity, ego-strength and social support on subjective well-being of bronchial asthma and hypertensive patients. The role of these variables in respiratory disorders has not been studied extensively. Also the effect of the ego-strength on subjective well-being of respiratory and cardiovascular disorder patients has not been studied.

It is accepted that the findings of this investigation would have much relevance for improving the health status and quality of life of bronchial asthma and hypertensive patients.
Research Objectives

The main objectives of the present study are as follows:

1. To determine the relationship between subjective well-being and religiosity, subjective well being and social support and subjective well-being and ego-strength, religiosity and ego-strength, religiosity and social support, ego-strength and social support among male and female patients of bronchial asthma.

2. To determine the relationship between subjective well-being and religiosity, subjective well being and social support and subjective well-being and ego-strength, religiosity and ego-strength, religiosity and social support, ego-strength and social support among male and female patients of hypertension.

3. To determine the relationship between subjective well-being and religiosity, subjective well being and social support and subjective well-being and ego-strength, religiosity and ego-strength religiosity and social support, ego-strength and social support among male and female patients of bronchial asthma and hypertension.

4. To determine the partial correlations between subjective well-being and religiosity scores (when the variables of ego-strength and social support are partialled out), between subjective well-being and ego-strength scores (When variables of religiosity and social support are partialled out), between
subjective well-being and social support (when the variables of religiosity and ego-strength are partialled out), between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out), between religiosity and social support (when the variables of subjective well-being and ego-strength are partialled out) and between ego-strength and social support (when the variables of subjective well-being and religiosity are partialled out), among male and female patients of bronchial asthma.

5. To determine the partial correlations between subjective well-being and religiosity scores (when the variables of ego-strength and social support are partialled out), between subjective well-being and ego-strength scores (when variables of religiosity and social support are partialled out), between subjective well-being and social support (when the variables of religiosity and ego-strength are partialled out), between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out), between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out, between religiosity and social support (when the variables of subjective well-being and ego-strength are partialled out) and between ego-strength and social support (when the variables of subjective well-being and religiosity are partialled out), among male and female patients of hypertension.
6. To determine the partial correlations between subjective well-being and religiosity scores (when the variables of ego-strength and social support are a partialled out), between subjective well-being and ego-strength (when the variables of religiosity and social support are partialled out), between subjective well-being and social support (when the variables of religiosity and ego-strength are partialled out), between religiosity and ego-strength (when the variables of subjective well-being and social support are partialled out), between religiosity and social support (when the variables of subjective well-being and ego-strength are partialled out) and between ego strength and social support (when the variables of subjective well-being and religiosity are partialled out), among male and females patients of bronchial asthma and hypertension.

7. To determine the significance of partial r (r12.34, r13.24, r14.23, r23.14, r24.13, r34.12) at the 0.95 confidence interval among male and female patients of bronchial asthma.

8. To determine the significance of partial r(r12.34, r13.24, r14.23, r23.14, r24.13, r34.12) at the 0.95 confidence interval among male and female patients of hypertension.

9. To determine the significance of partial r (r12.34, r13.24, r14.23, r23.14, r24.13, r34.12) at the 0.95 confidence interval
among male and female patients of bronchial asthma and hypertension.

10. To determine the multiple coefficients of correlations between scores actually earned and scores predicted on the subjective well-being from the three variables – religiosity, ego-strength and social support among male and female patients of bronchial asthma.

11. To determine the multiple coefficients of correlations between scores actually earned and scores predicted on the subjective well-being from the three variables - religiosity, ego-strength and social support among male and female patients of hypertension.

12. To determine the multiple coefficients of correlations between scores actually earned and scores predicted on the subjective well being from the three variables, religiosity, ego-strength and social support among male and female patients of bronchial asthma and hypertension.
CHAPTER - II

Review of Literature
The review of Literature includes only those studies which have relevance and relation with the variables of the present study. The main thrust of the present study is on the impact of religiosity, ego-strength and social support on subjective well-being of the bronchial asthma and hypertensive Patients. Although reviews of the relation between subjective well-being and social support have been published, no researches to date have examined the association of subjective well-being and ego strength, religiosity and ego strength. Studies are grouped into the following main heads:

**SUBJECTIVE WELL-BEING**:

Mcllvane and Reinhardt (2001) examined the interactive relationship of high and low friend and family support for adaptation to chronic vision impairment among in 241 men and women (aged 65-99 yrs old). Two 2 (High/low family support) x 2 (High/low friend support x 2 /Gender) multivariate analysis of covariance tested for Psychological well-being, one with qualitative support measures, the other with quantitative support measures. Two analyses of covariance models tested for adaptation to vision loss. A significant multivariate 3-way interaction effect for quantitative support was found. Women with high support from both friends and family had better psychological well-being. Whereas men with high support from both friends and family or
just from family had better psychological well-being. Two univariate main effects showed that participants with high qualitative friend support and high quantitative family support had better adaptation to vision loss. Findings demonstrate the complexity of measuring and understanding relationship among social support, well-being, and domain-specific adaptation to chronic impairment.

Peck (2001) examined that lower levels of subjective well-being are associated with increased illness and death. Studies of elder morbidity and mortality increasingly have explored the link between social and psychological aspects of life to subjective well-being, and to health and disease. This paper presents a conceptual model of subjective well-being based on the process that people use to appraise their lives and on life task completion. Theories of social cognition inform the life appraisal process and provide a framework for interventions. Life review therapy is detained as a social work intervention to enhance the subjective well-being of older adults.

Daaleman, Cobb and Frey (2001) identified and described elements of patient reported, health related spirituality. A qualitative study utilized focus group interviews of 17 women with type 2 diabetes mellitus; there were 18 controls. Participants narratives were coded into 8 conceptual categories; (1) change in
functional status, (2) core beliefs, (3) medical/disease state information gathering and processing, (4) interpretation and understanding (5) life scheme, (6) positive intentionality, (7) agency, and (8) subjective well-being. A change in functional status was the catalyst for 2 process-oriented categories, Medical disease state information gathering and processing, and the higher order interpretation of understanding of life events. Participants tied the attitudes and practices of positive intentionality with agency, or the use of exertion of power through belief, practice or community. They outlined positive affective and cognitive components of subjective well-being. Patients described several interrelated elements and a process of events in their depiction of spirituality in healthcare settings. Patients reported spirituality is predominantly a cognitive construct incorporating the domains of life scheme and positive intentionality.

Steverink, Wasternof et al (2001) examined the personal experience of aging, the resources relevant to it, and the consequences for subjective well-being in a sample of 4,034 German adults aged 40-85 yrs old. The data revealed 3 dimensions of aging experiences as particularly relevant: (a) physical decline (b) continuous growth, and (c) social loss. Not only being younger but also having better subjective health, higher income, loss loneliness, higher education, and greater hope were negatively
associated with physical decline and social loss are positively related to continuous growth. The number of children participants had played no role. All three dimensions of the aging experience were also found to be related to both positive and negative affect and, with the exception of physical decline, to life satisfaction.

Hilleras, Aguero, Hedda and Winblad (2001) examined the factors that either increase or decrease well-being in both young and old people. Many factors have been studied in relation to well-being but only some have been found to be associated with it. These factors are demographic (age, sex, culture, marital status), social (Socio economic status, having children, religion, social contacts) or are related to personality, life events, health, and activities. However some of these factors have a stronger association than others.

Harrington and Loffredo (2001) examined the relationship between psychological well-being, life satisfaction, self-consciousness, and the four Myers-Briggs Type indicator dimensions. The participants were 97 college students. All the subjects were administered four instruments, the Psychological well-being inventory (C.D. Ryff, 1989), the satisfaction with life scale (E. Diener et al, 1985), and the self-consciousness scale. Revised (M.F. Scheier and C.S. Carver, 1955), and the MBTI (from G self-scoring), MANOV as revealed significant differences
on three of the four dimensions of the MBTI with extraverts showing higher psychological well-being and life satisfaction and lower self-consciousness than introverts. Correctional analyses showed that most dimension of psychological well-being were negatively related to self-consciousness. The relationship between life satisfaction and personality variables are discussed.

Wallace, Bisconti and Bergeman (2001) Examined resilience resources as they relate to health and well being in an elderly sample. It is suggested that these resources serve as reserves than an individual can use to compensate for age related loss. Of particular interest in this study are the internal personality reserve hardiness, and the external reserve, social support in 443, Ss, aged 60-95 years. Hardiness was examined as both a mediator and moderator of the relation between social support ie, quantity of family support and friend support) and outcome (depression life satisfaction, and self-reported health). Across type of support and outcome, evidence was found for the mediational model, suggesting that the relation between social support and outcomes decreases once hardiness is taken into account. Model-fitting analyses provided additional support for the mediator model once error had been attenuated overall, these results suggest that consideration of either construct alone may be loss complete than consideration of them in combination.
Eiser, Riazi, Eiser, Hammers and et al (2001) examined psychological well-being and individuals representations of their illness among 96 patients with type 1 diabetes and 139 patients with type 2 diabetes. Metabolic control and the presence of diabetetic complications (e.g., retinopathy, neuropathy) were also recorded. Type 2 patients tended to be older and be experiencing more complications than type 1 patients. Women reported lower well-being than men. Type 1 and Type 2 patients did not differ in terms of well-being, but the predictors of well-being were somewhat different in 2 groups. In both groups, well-being was related to control beliefs, (Confidence in self management and ability to delay complications) and to lower ratings of the extent to which diabetes interfered with everyday activities. For type 1 patients only, well-being also related to a tendency to perceive their diabetes as having minimal impact on their lives. Metabolic control showed no consistent relationship with Psychological variables, but the number of complications significantly predicted lower well-being among Type 2 patients only. It is argued that well-being is a function both of illness representations and the actual experience of complications, which are more prevalent among those with type 2 than type 1 diabetes.

Diener, Lucas, Oishi, Shigehiro and suh (2002) in 2 large international studies of subjective well-beings, the authors
examined that whether happy and unhappy individuals weighted 8 life domains (health finances, family, friends, recreation, religion, self and education) differently when constructing life-satisfaction Judgements. In both studies, regression equations predicting life satisfaction showed that there were significant interactions between happiness and a person’s best and between happiness and a person’s worst domain, even after controlling for participant’s standing on all other domains. Happy participants weighted their best domains more heavily than did unhappy individuals, whereas unhappy individuals weighted their worst domains more heavily than did happy individuals. Thus happy and unhappy people used different information when constructing satisfaction judgements.

Vitters, Nilsen and Fredrik (2002) examined two things (1) to analyze and explore the conceptual structure of subjective well-being SWB, neuroticism (n) and extraversion (E), and (2) to compare the effect size of N and E as predictors of SWB. The sample comprised 461 participants representative of adult population in Northern Norway. Analyses were conducted by means of structural equation modeling (SEM), and the results on (1) supported the notion of an overall subjective well-being construct sustained by the three nested dimensions of life satisfaction, positive affect, and negative affect. A simple factor structure for N and E was not supported, and considerable
modification was needed to provide even a Mediocre goodness of fit for the trait model. On (2), N explained eight times as much of the SWB variance as did E. Moreover, through comparison of several models it was revealed that if E is the sole predictor of SWB, the influence of E on SWB is overestimated by a factor of seven. Since N and E are strongly and negatively correlated, the model comparison demonstrates the importance of including both E and N as independent variables in regression models of SWB.

RELIGIOSITY:

Saunders, and Kong (1983) examined the role of Churches in hypertension management. Describes three year experience in the establishment and functioning of Church-based hypertension programs in ten medium to major size U.S. cities, also describes hypertension screening and education programs.

Trappier and Endicott (1997) Comments on the article by K.S. Kendler et al (1997) which examinable stress buffering properties of religiosity. The authors note their study (B. Trappler et al 1995) of a homogeneous group of returnees to the Lubrich scet of orthodox Judaism. it was concluded the SS ability to internalize religion and make effective use of a close community support system to butter them against stressful life events appear cal to have been influence by genetic or environmental factors before their religious conversion
Hettler and Cohen (1998) examined the stress buffering effect of an intrinsic religious orientation for a community sample of adult Protestant Churchgoers. At time 1, participants completed measures of intrinsic religiousness, religious activity and dysphoria. At time 2 eight months later, they completed measures of negative life and dysphoria. For participants from liberal protestant Churches. (e.g. Methodist), intrinsic religiousness served as a stress-buffer in the predication of time 1-time2 residual change in dysphoria. Single item measures of religious importance, frequency of prayer, and frequency of Church attendance served as stress-buffers for liberal participants, but not for conservative participants. The non-significant effects for the later participants are attributable to their restricted range on the religion variables. The result for the former participants suggests that religious “Commitment” is an individual difference variable that influences adjustment to negative life events.

Meisenhelder and Chandler (2000) questioned 71 native Americans (aged 65-92 yrs.) living in the general community on their frequency of prayer, importance of faith, and their health status. The researchers hypothesized that people with higher scores in faith and prayer would experience a more positive health status. Self-reports of health indicated a high level of functioning overall. Older people and those living alone had poorer physical
and emotional health outcomes than younger elders and those living with one or more persons, although neither age nor living situation was related to mental health people who prayed more often and those who indicated a high importance of their faith scored higher in the mental health sub scale, confirming the hypothesis for this dimension of health.

**RELIGIOSITY AND PSYCHOLOGICAL WELL-BEING:**

Witter, stock, Okum, and Haring (1985) examined religion and subjective well-being in adulthood: 56 religion/subjective well-being effect sizes examined., quality of study ratings made using a survey evaluation instrument used by Kohr & Suydam (1970)., the mean sample size weighted correlation was 0.16 (9570 CI 0.14-0.25)., study quality ratings were unrelated to effect size., religion was more strongly related to well-being in earlier studies., relationship was stronger in older than younger subjects, but not by sex., mean effect sizes were greater for religious activity (weighted m=18) than for religiosity (.13)., religion is as strongly, or more strongly related to subjective well-being. 2-6% of variance in SWB of adults is account for by religious belief which was larger than marital status, economic well-being, and other variables.

Courtenay, Poon, Matin, Clayton and Johnson (1992) measured religiosity by 23-item questionnaire of Faulkner and
DeJong (1966) belief, knowledge, ritual, attendance, prayer, Bible, experience, and consequential, ritual dimension was uniformly positive related to health conditions: cardiovascular (.22, P<.01), neurological (.24, P<.01), musculoskeletal (.24, P<.05), respiratory (.23, P<.01), and overall (.23, P<.01). Overall religiosity score was positively related to neurological and musculoskeletal disorders. Results suggests that religious persons likely to use religious coping as a method of dealing with health problems, for overall religiosity and each of the 5 dimensions, centenarians (n=31-35) had the highest mean score, followed by octogenarians (n=33-37) and the sexagenarians (n=44-47), suggest that for religious belief, knowledge, and reliance on religion in daily life, there is a linear increase with age.

RELIGIOSITY AND WELL BEING:

Atchley (1997) examined whether the subjective importance attached to being a religious person influenced health or psychological well-being 14 years later. Data were drawn from the Ohio longitudinal study, a study of aging and adaptation in a panel of more than 1,100 adults who were aged 50 or over when the study began in 1975. About two third of the panel reported consistently positive attitudes towards being religious throughout the study, about 16% were consistently negative in terms of the importance being religious had no predictive value in
understanding variation in health or psychological well-being in 1991. Religious affiliation and frequency of attending religious function were also unrelated to health or psychological well-being. These results call into question conclusions of earlier reviews (e.g., Koenig, 1994-95) of the literature.

Koenig (1998) examined the prevalence of religious beliefs and practices among 455 medically ill hospitalized older adults (mean age 70.2 yrs) and related them to social, psychological and health characteristics. Ss admitted to the general Medicine, Cardiology and neurology services of a University medical center completed measures of religious affiliation, religious attendance, private religious, intrinsic religiosity and religious coping. Demographic, social, psychological and physical health characteristics were also assessed. 53.4% of Ss reported attending religious services once per week or more often; 58% prayed or studied the Bible daily or more often. Over 85% of Ss held intrinsic religious attitude, and over 40% spontaneously reported that their religious faith was the most important factor that to cope. Religious variables were consistently and independently related to race, lower education, higher social support and greater life stressors. Religious attendance was associated with less medical illness burden and lower depressive symptoms.
Maltby, Lewis and Day (1999) examined the role of religious acts between measures of religious orientation and Psychological well being, and also examined the theoretical view that religion can act as a coping mechanism correlational statistics, principle components analysis with Oblimin rotation and multiple repression were used. Ss aged (18-29 years) were administered questionnaire measures of three aspects of religious orientation (intrinsic, extrinsic; Quest), frequency of personal prayer and Church attendance, alongside measures of depressive symptoms, trait anxiety and self-esteem. A number of significant correlations were found between measures of religiosity and psychological well being, a multiple regression analysis using identifiable religious components suggests that frequency of personal prayer is the dominant factor in the relationship between religiosity and Psychological well-being. The results suggest two point (1) that the correlation between a number of measures of religiosity and Psychological well-being may be mediated by the relationship between frequency of personal prayer and psychological well-being. (2) that personal prayer may be an important variable to consider within the theory of religious coping.

RELIGIOSITY AND BLOOD PRESSURE:

Hixon, Grachow, Harvey and Morgan (1998) examined the association between BP, selected health behaviours, and various
dimensions of religiosity among 112 females (aged 35-85 yrs) of Judeo-Christian faiths. Resting BP measures were taken with an automated sphygmomanometer, height and weight were measured to determine body mass index, and intermediate health variables (e.g. physical activity, smoking, diet, and Alcohol consumption) were measured by questionnaire. A multifactorial questionnaire was used to assess various dimensions of religiosity. Multiple regression path-analyses were conducted to determine the direct and indirect effects of religiosity on BP with age and body mass index controlled atavistically. The results supports a direct relationship between religiosity. Results also indicate that religious experiences may exert a greater beneficial effect on diastolic BP in older (50-80 yrs) age group.

Hixson, Gruchow and Morgan (1998) examined the relation between religiosity, selected health behaviors, and blood pressure among adult females. Cross-sectional data were obtained on 112 white female of at least 35 years of age and of Judco-Christian faith. Resting blood pressure, height and weight were measured to determine body mass index (BMI). Physical activity, smoking, diet, and alcohol consumption was measured by questionnaire. A multifactorial questionnaire was used to measure religiosity. Multiple regression path analyses were conducted to determine the direct and indirect effects of religiosity on blood pressure. Age
and BMI were controlled statistically. The direct effects of religiosity on systolic blood pressure (SBP) and diastolic blood pressure (DBP) were more substantial than the indirect effect through the intermediate health variables, though not significant. In general, DBP was more influenced by religiosity than SBP, and the dimensions of intrinsic religiosity and religious coping were most influential.

Koenig, George Cohen, Hays, Blazer, Larson (1998) examined the relationship between religious activities and blood pressure in community-dwelling older adults. Blood pressure and religious activities were assessed in a probability sample of 3,963 persons age sixty-five years or older participating in the Duke EPESE Survey. Participants were asked if their doctor had ever informed them that they had high blood pressure and if they were currently taking medication for high blood pressure. Systolic and diastolic blood pressures were measured following a standard protocol. Data were available for three waves of the survey (1986, 1989-90 and 1993-94). Analyses were stratified by age (65-74 vs. over 75) and by race (Whites vs Blacks) and were controlled for age, race, gender, education, physical functioning, body mass index, and, in longitudinal analyses, blood pressure from the previous wave. Cross-sectional analyses revealed consistent differences in measured systolic and diastolic blood pressure
between frequent (once/wk.) and infrequent (.0001). Participants told they had high blood pressure; religiosity active persons were more likely to be taking their blood pressure medication.

**RELIGIOSITY AND HYPERTENSION MANAGEMENT:**

Brown (2000) examined the role of religiosity in hypertension management among African Americans. Data were collected from in depth; personal interviews with 20 African Americans aged (23-78 yrs) who had been diagnosed with hypertension for at least 1 year. A majority of the participant used their religious believe as protective, control and coping mechanism in the management of hypertension. Their personal religious commitment enables them to feel protected from immediately and long term negative consequences of hypertension, as well as find meaning in and exert control over hypertension management. Further, more religious believe served to enhance their ability to cope with having hypertension. These findings support the utility and value of religiosity in the management of hypertension among African American.

**SOCIAL SUPPORT:**

Walsh and Walsh (1987) examined social support, assimilation and biological affect on blood pressure levels. Sample consisted of 137 immigrants in Toledo, Ohio (50 percent men and 50 percent women) snow-balling technique was used to acquire the sample.
blood pressure readings were taken using standard procedure with patients seated. A “biologic effective blood pressure” was calculated using a standard formula, which basically involved averaging the systolic and diastolic blood pressures. Frequency of Church attendance was assessed as never or only on special occasions, once or twice a month, once a week, and more than once a week (1-4). Frequency of religious attendance was significantly associated with assimilation (measured with a 12-item major assessing respondents acceptance of and closeness to America and Americans), (0.36, P<.0001) and was inversely related to blood pressure (-.17, P<.05). After controlling for age, sex, positive affect, general cardiac health, assimilation, occupation, education, income, and marital status using multiple regression, Church attendance continued to inversely predict blood pressure (-.16, P<.05).

Cheung, sun, Mak and Fung (1997) investigated the differential effects of social support on the psychological well-being of sociotrophic and autonomous individuals using 2 wave prospective design, 75 college students responded to the Chinese sociotropy-Autonomy scales (SAS). Index of well-being, the Chinese general health questionnaire, the Chinese state anxiety inventory, and the inventory of socially supportive behaviours Data were analysed by means of multiple regression analysis
controlling for psychological outcome variables at time 1. Moderating effects of sociotropy autonomy were investigated by examining the significance of the interactions of SAS and social support. The results show that whereas perceived availability of social support contributes to the prediction of psychological well-being of the sociotropic individuals, the availability is not significant or even inimical to those autonomous individuals. The effect holds regardless of the nature of social support (i.e., whether they are emotion focused or problem focused). The findings further suggest the importance of sociotropy autonomy personality dimensions. Implications for social support intervention are discussed.

Krause (1997) assessed the relationship among received support, anticipated support, social class, and mortality. Anticipated support is defined as the belief that significant others will provide assistance in the future should the need arise. Data from a prospective nation-wide survey of 60 yrs olds and older in England, Scotland and Wales indicate that greater received support is associated with an increased mortality risk. The findings further suggest that anticipated support is associated with lower mortality risk, but these beneficial effects are evident only in the upper social class. Finally, the analysis suggests that there may be a reciprocal relationship between received support and anticipated
Bosworth and Schaie (1997) examined the relation of social networks and perceived social environment (PSE) to health outcomes and cost utilization over 1 year in a community sample of 387 Ss (aged 36-82 yrs). Two analytical strategies, a variable oriented approach and a subject-oriented approach, were used to complement each other: Structural equation modeling assessed that direct relationship between social relationship patterns were related to health outcomes. Married individuals with low levels of social networks had increased total health care costs, outpatient costs, and primary care visits. Members of the cluster groups with greater health problems were more likely to be isolated, had the least social contact, and had lower levels of education and income.

Chou (1999) examined the relationship between social support and 3 measures of subjective well-being depressive symptomatology, negative affect, and positive affect, among 475 Hong Kong Chinese young adults (aged 16-19yr). Measure completed by the SS included the center for Epidemiological studies, depression scale and the multidimensional scale of perceived social support. Significant bivariate relationships were found between positive affect and all dimensions of social support (including social network size, social contact frequency, satisfaction with social support, instrumental support, and helping
others), except composition of social network. Helping others variables and relationship satisfaction variables were negatively related to both depressive symptoms and negative affect. Multiple regression models revealed that satisfaction with relationship with family members and friends were consistently associated with all measures of subjective well-being and numbers of friends felt close to was positively related to positive affect.

Walen and Lachman (2000) Examined the (1) association of social support and strain with psychological well-being and health (2) investigate whether these associations dependent on relationship type (Father, family, friend). (3) examined the buffering effects of support on strain (both with in and across relationship type) and (4) test the extent to which these associations differed by age and sex. 2,348 adults aged (25-75 years) who were married or cohabitating participated in the study. Positive and negative social exchanges were more strongly to psychological well-being than to health. For both Sexes, partner support and strain and family support were predictive of well-being measures. Partner strain was also predictive of well-being and health outcomes more often for women. Authors find that supportive networks could buffer the detrimental effects of strained interactions, friends and family served a buffering role more often for women than for men. These results suggest that
future research consider the effects of strain and how support and strain interact, differentiate among sources of support and strain and explore variations by age and sex.

Savelkoul, Post, de witte and vanden (2000) examined the relationship between Social support, coping and subjective well being by testing three hypothesis: (1) Social support influences subjective well-being via coping, (2) Coping influences subjective well-being via social support, (3) there is a reciprocal relationship between social support and coping and both concepts influence subjective well-being. Data were analysed from 628 patient with one or more chronic rheumatic disorders (5) affecting the joints, in some patients combined with another rheumatic disease (no fibromyalgia). Although causal inferences are not possible, the results present a plausible causal sequence in supporting the second hypothesis. This is only true, however, for coping by awaiting/avoidance led to less social support and this decreases in social support influences subjective well- being negatively.

Edwards, Hershberger, Russell and Markert (2001) examined the unique contributions of positive social support and negative social exchange in the relationship between stress and health symptoms, using data from 206 undergraduates at a large state university. Negative social exchanges accounted for more variance in physical health symptoms than did life-event stress, daily
hassles, or social support. The relationship between negative social interaction and physical symptoms was not the result of variance shared with psychological well-being. The importance of attending to negative aspects of social interaction among university students in terms of their health and well-being is discussed.

Lutz and Lakey (2001) examined that social support and other social judgments are composed of several distinct components, of which relationship effects are an important part. With regard to support judgements, relationship effects refer to the fact that when judging the same targets, people differ systematically in whom they see as supportive. One explanation for this effect is that people differ in how they combine information about targets to Judge supportiveness. Participants rated the supportiveness of hypothetical targets and targets from their social networks. Multilevel modeling identified the traits participants used to make support judgements. There were significant differences in the extent to which participants used different target personality traits to Judge supportiveness. In addition participant neuroticism predicted the extent to which participants used target neuroticism and agreeableness to Judge supportiveness.
Tseng and Wang (2001) investigated subjectively perceived quality of life and related factors of elderly nursing home residents. 161 nursing home residents (aged 65-96 yrs) completed rating scales concerning quality of life, health status, social support and family interaction frequency. Results show of residence in the nursing home was significantly negative relative to the quality of life. Physical function, activities of daily living, social support from nurses, social support from nursing aids, social support from families, and frequency of family interaction were significantly positive relative to the quality of life. Activities of daily living, social support from nursing aids, socio economic status, physical function, and frequency of interaction with family were found to be significant predictors of quality of life.

Taylor, Chatters, Hardison and Riley (2001) examined the influence of sociodemographic and family, friendship, fictive kin, Church, and neighbour network variables on two measures of subjective well-being (i.e. life satisfaction and happiness) among national sample of African Americans. The analyses were conducted on the national survey of Black Americans, a National Cross-Section study of the adult (age 18 and older). Black population (n=2,107). Sociodemographic (i.e. age, income, region, health, marital status, urbanicity) and social relations and network factors (i.e., subjective family closeness, support from family;
number of friends, presence of fictive kin, Church attendance and frequency of contact with neighbors) were significantly associated with subjective well-being. The findings are discussed in relation to previous work on the sociodemographic, health and social network correlates of subjective well-being.

Olstad, Sexton and Sgaard (2001) examined that whether the buffer hypothesis (social support or social network may affect mental health by buffering the negative effect of stress on mental health) was tested in 3-population based health surveys which took place in 1987, 1990 and 1993 in 5 coastal municipalities in Finnmark, Norway. All persons ages 40-62 yrs and a random sample of those aged 20-39 yrs were invited, and 77%, 74% and 70% attended the 3 health surveys, respectively. Stress was divided into acute stress, and chronic stress (having a chronic disease, disability pension, being a single percent or providing long term nursing care for someone in the family) when all possible stressors and the sum of social network/social support/network buffered the deteriorating effect of total stressor score upon mental health.

Schronder and Schwarzer (2001) examined the effects of personal resources of both heart patients and their close social partners on patients coping and quality of life. Generalized personal resources (self-efficacy beliefs, dispositional optimism,
self regulation competence) and outcomes were assessed by questionnaire 1-3 days before surgery (n=122) and again 6 mo later (n=50) outcomes variables were coping style, social resources (Social support and social integration), emotional states and further measures of quality of life. Patients personal resources were dominant in the prediction of most of the outcomes. Partners resources were uniquely related to social support, social integration, and quality of life as perceived by the patients. Further, partners personality resources predicted change in patients loneliness and energy levels during the 6-mo interval.

Hallaraker, Arefjord, Havik and Mieland (2001) examined the relationship between quantitative and qualitative indicator of social support and anxiety, depression and use of health services in a sample of 37 wires of myocardial infraction (MI) patients. In a prospective design, the wives were interviewed during the acute phases of the illness, three months and 10 years post index MI. Congruent with previous research, the quantitative aspect of social support, defined as a number of persons giving help, was unrelated to adjustment, whereas, qualitative aspect of social support, defined as the wives dissatisfaction with social support, was associated with depression and use of health services. The observed association indicated, however, on effect in the opposite direction of the social support model. The findings were
unexpected and may be due to small sample.

Bohachick, Taylor Sercika, Reader et al. (2002) examined the influence of psychosocial resources of psychological recovery after heart transplantation. 28 patients were surveyed during their hospitalization after transplant surgery and 6 months post transplantation. Scales from coping with serious illness battery were used to measure psychosocial resources (Social support and Personal Control and Psychological and Functional outcomes. Psychosocial resources assessed during hospitalization were associated with recovery outcomes at 6 months post transplantation. Personal control was positively correlated with recovery outcomes at 6 months transplantation. Personal control was positively correlated with optimism well-being, and satisfaction with life (r=0.41 to 1.49) and negatively correlated with anger (r=-0.57) and depression (r=-0.52). Social support network helpfulness and attachment with others were correlated with psychological outcomes (r=0.41-0.59) and functional outcome (r=0.42-0.47). Efforts directed towards enhancing perceptions of personal control, social support network helpfulness, and attachment may be useful for promoting psychosocial recovery.

Letvak (2002) examined that social support has been found to have a direct effect on well-being of families and individuals. The mentally ill are considered to be vulnerable as a group, those
who are mentally ill and reside in rural communities are at a greater disadvantage due to limited cures to health care. Specific strategies are presented which will assist rural health nurses in providing support symptoms necessary to help rural residents in managing and coping with stress and mental health problems.

De Groot (2002) examined roll of social support for cancer patients, given the high level of distress typically associated with the diagnosis and the treatment of cancer. Social support has been described as comprised of components that are informational, instrumental, emotional, affirmation, and appraisal. Although these elements may overlap, adequate assessment of the various dimensions will ensure that appropriate clinical applications can be drawn from research findings. Gender, age, marital status, and education, may influence social support needs and social network size and the perceived adequacy of social support for cancer patients, as well as for parent caregivers of married cancer patients in relation to depression and health related quality of life.

Gleeson, Bernal and Woolley (2002) examined the composition of the support network, the type of assistance needed, the degree of satisfaction with support received, and the relationship between social support and diabetes self-management. Overall, the Ss had fairly large networks, composed primarily of family members. Ss were least satisfied with the help they
received for diabetes-related self-care, and financial assistance-
social support was not strongly related to a diabetes self-
management. The authors advise community health nurses to
provide education and resources for support persons and carefully
evaluate the support network, not only for availability, but also for
satisfaction. Efforts should be directed toward developing
alternative support for those without available family.

Jou and Fukada (2002) examined the effects of reciprocity
and sufficiency of social support on the mental and physical health
of 488 Japanese University students with different levels of
stressors. The questionnaire included items that measured support
provided for, request by, requested of and received from others. It
also addressed negative affect associated with support
relationships, as well as the levels of stressors, and mental and
physical health. The participants support relationships with others
were fairly reciprocal. Although being over benefited (i.e.,
receiving more support than one provides) was selected to stronger
feelings of indebtedness, being over benefited (i.e., providing
more support than one receives) was related to stronger feelings of
burden. In sum, when the participants receive less support than
they requested and when they provided less support than others
requested, they tended to become less mentally and physically
healthy. Reciprocity of support appeared to have both direct and
buffering effects, however, the effects of sufficient support on health did not vary with levels of stressors.

Hogan, Linden and Najarian (2002) examined that presence of support has repeatedly been linked to good long-term health outcomes based on demonstrations of better immune function, lower blood pressure and reduced mortality. Using a computerized search strategy, 100 studies that evaluated the efficacy of such interventions were located. For the purpose of the review and evaluation; studies were subdivided into groups vs. individual interventions, professionally led vs. peer provided treatment, and intervention where an increase of network size or perceived support was the primary target vs. those where building social skills was the focus. On the whole, this review provided some support for the overall usefulness of social support interventions.

Nezlek, Richardson, Gran, Schatten and Elizabeth (2002) examined a sample of 113 healthy older adults (mean age 71.2 yrs.) used a variant for the Rochester interaction record to describe the social interactions they had each day for two weeks. They also completed various measures of psychological well being (the life satisfaction index A, the satisfaction with life scale, the UCLA loneliness scale, and the emotional and social loneliness scale). A series of multilevel random coefficient analyses found that life satisfaction scores were positively related to how
enjoyable interactions were, how self-assured people felt when interacting, how much control they felt they had over interactions, how responsive others were to their needs, and how socially active they were. Analyses that took participants marital status into account suggested, however that interaction outcomes and life satisfaction were related only for married participants, and that these relationships were primarily due to interaction outcomes with spouses.

**PSYCHOSOCIAL CORRELATES OF BRONCHIAL ASTHMA:**

Kulshrestha, Khan, Siddiqui, Bhargaw and Khan (1992) examined 100 families registered at Urban Health Training Centre (UHTC) of community medicine and T.B. and Chest O.P.D. within hospital from 1.7.92 to 30.9.92. Patients were thoroughly questioned. Psychological and Social profile was also studied. Out of 1000 families total patients were 176 and 102 O.P.D. patients were also included. The correlation of Bronchial Asthma was found significantly in low socio-economic status and dusty environment. Among psychological profile, death in family, loss of Job, change of house job, quarrel, affected bronchial asthma in the same decreasing order.

Rietveld, Beest and Everaerd (2000) examined the hypothesis that stress induces breathlessness and not airway obstruction. Stress was induced by a frustrating computer task in
30 adolescents with asthma and 20 normal controls, aged 14-19 years. Stress measures were self-reported emotions, heart rate and blood pressure. Respiratory measures were respiratory rate (RR), end tidal CO$_2$, deep inspirations signs asthma measures were lung function, wheeze, cough and breathlessness. All measures confirmed high levels of negative emotions and stress. None of the participants developed airways obstruction, they had no reduction in lung function. Wheeze was absent and cough negligible. However breathlessness increased in all participants with asthma and excessively in many. The mean breathlessness was higher then during induction of actual airways obstruction with provocative agents in previous studies. End tidal CO$_2$ showed that breathlessness could not be explained by hypocapnia. The authors conclude that stress can be sufficient to induce breathlessness in patients with asthma.

Grant, Lyttle and Weiss (2000) examined the relations between socioeconomic, factors and race/ethnicity as risk factors for asthma mortality. A cross sectional study was conducted by US mortality records from 1991 through 1996. Higher standardized mortality ratio were seen for Black vs Whites (3.34 vs 0.65) low vs high educational level (1.51 vs 0.69) and Low vs high income (1.46 vs 0.71 vas 0.69). Excess mortality for Blacks vs Whites was present in the highest and lowest quintiles of median county
income and educational level. The disparity in asthma mortality rates according to median county income and education remained after control for race/ethnicity. Results indicated that Black race/ethnicity appears to be associated, independently from low income and low education, with an elevated risk for asthma mortality.

**PREVALENCE OF BRONCHIAL ASThma:**

Shah, Mehrotra and Dhar (1994) examined data of Bronchial Asthma in patients admitted in Bombay Hospital. They stated that Bronchial Asthma is a clinical syndrome characterized by paroxysmal dysphoea and wheeze due to increased resistance to the flow of air through narrowed bronchi brought about by spasm of bronchial smooth muscle. Case sheets of 200 in patients diagnosed as bronchial Asthma under ICD code 493 were analyzed. Prevalence was found to be 0.9% of total admissions. 19 were smokers, 12 gave family history of Asthma. 164 were Hindus, 20 were Christians and 15 Muslims. Majorities were suffering from Cardio-Vascular, central nervous system and gastrointestinal tract disorders as well as diabetes as associated disease either as past illness or affected subsequently.

Khan, Roy, Christopher and Cherian (2002) examined that the prevalence of self-reported Bronchial Asthma, and related disorders in Vellore in South India. Asthma and related disorders reported to be rare in poor and developing countries and their
prevalence is expected to rise with urbanization. Investigation was carried out by using a simple questionnaire-based data collection. The subjects were employees belonging to a particular nationalized bank. A significant number of subjects with symptoms suggestive of asthma self reported themselves as non-asthmatic. There was a significant association between those who had symptoms of asthma.

**HYPERTENSION PREVALENCE:**

Goel, Singh and Kaur (1992) designed a case control study. The study was carried out in 6 villages of Chirai gao block, from July 1992 to Nov, 1992; out of which 117 cases were diagnosed as hypertensive giving an overall prevalence rate of 7.94% (5.332%) in males and 9.59% in females. Two controls, age and sex matched, were selected against one case. Various risk factors like Socio-economic status, Obesity, Smoking habits, tobacco chewing habits, alcohol addiction in general and dietary intake in particular were studied in detail.

Gupta and Gupta (1999) examined the prevalence of hypertension and blood pressure trends in a large population in Metropolis. They conducted a house-to-house survey in South Mumbai. A total of 99,598 individuals were studied. Analyzable data were available in 99,589 subjects, 40,067 (40.2%) males and 59,522 (59.8%) females, 625 (1.56%) males and 1574(2.64%)
females were aware of the presence of hypertension. There were increases in the mean systolic as well as diastolic BP with age (P<0.001). As compared to females, the mean systolic BP was mere in males under 40 years of age, after this age the systolic BP was greater in females. According to JNC-VI guidelines hypertension prevalence was 43.8% in males and 44.5% in females. There was a significant increase in the prevalence of hypertension with age. The prevalence of mild hypertension (stage I) was more at younger age groups and decreased with age while stage II hypertension increased and the prevalence of stage III and IV hypertension remained relatively constant. There is a higher prevalence of hypertension in Urban adults of Mumbai than reported in studies from North Indian cities of Jaipur and Delhi.

National Institute of Health, Lung, and Blood Institute, National High Blood Pressure Education Programme (1999) identifying and treating high blood pressure to reduce the risk of cardio-vascular disease and associated morbidity and mortality. The positive relationship between SBP and DBP and cardiovascular risk has long been recognized. This relationship is strong, continuous, graded, consistent, independent, predictive, and aetio logically significant for those with and without coronary heart disease.
Varma, Swaminathan, Das, Kumar, Balachander (2000). Established a programme with the aim of screening patients 45 years or more of age, attending OPD in our hospital for hypertension. One thousand consecutive South Indian, drug naïve patients, 45 years and above of age, attending medicine OPD for non-cardiac complaints were screened with blood pressure measurements, using standard procedure by a single observer. Hypertension was detected in 141 (14.1%) patients. Combined hypertension was present in 86 (8.6%) patients, isolated systolic hypertension in 29 (2.9%), isolated diastolic hypertension in 24 (2.1%) and secondary systolic hypertension in 5 (0.5%) pseudohypertension was detected in 25 (2.5%) and White Coat hypertension in 23 (2.4%) patients. Male patients had significantly higher mean systolic blood pressure, diastolic blood pressure, pulse pressure and mean arterial pressure as compared to female patients. The occurrence of isolated systolic hypertension and pseudohypertension increased with age. While systolic blood pressure showed an increase with age, there was no significant variation in diastolic blood pressure with age. True isolated systolic hypertension formed only 34.8 percent of the total number of patients (83) with isolated elevation of systolic blood pressure. These results indicate a wide prevalence of hitherto undetected hypertension among patients visiting a general OPD. Active
screening for hypertension among people older than 45 years is imperative at the community level to detect the disease at an early stage and thereby reduce the associated morbidity and mortality.

Arya (2000) has identified that the cut off age for elderly person is India 60-65 years, in the USA is 75-80 years. Elderly people may have (i) systolic - diastolic hypertension, (ii) isolated systolic hypertension or (iii) pseudo-hypertension. The number of elderlies in 1990 was around 60 millions and by 2020 nearly 10% of population is likely to be above 60 years. Hypertension (HTN) is likely to be detected in 30-40% of those persons. Hypertension is present in 18% rural and 40% in urban elderlies. The 6th Joint Committee on Detection, Evaluation and Treatment of High Blood Pressure (JNC-VI) has identified age above 60 years as an independent risk factor for hypertension.

Chabra, Lal and Sharma (2001) examined the status of lifestyle modifications in hypertension. The prevalence of hypertension in India ranged between 16.89% and 23.7% in rural and between 30% and 33% in urban areas areas. As regarding dietary interventions, caloric restriction may influence the minimization of BP. Body weight reduction, less alcohol consumption, salt restriction; Potassium and Calcium supplementation can enhance the process of lowering BP. As regarding behavioural changes, stopping smoking, regular physical
exercise, relaxation therapies like Yoga, etc, have definite beneficial effect on hypertensives.

Ahlawat, Singh, Kumar, Kumari and Sharma (2002) examined the changes in the prevalence of hypertension and associated risk factors over a 30 years period a cross-sectional population survey in three randomly selected sectors of Chandigarh city. Study population consisted of 1181 individuals (570 males and 611 females) aged 35 years and above. A total of 1049 subjects were interviewed using a structural interview Schedule, and 937 were examined by a Physician. Blood pressure and anthropometric measurements were recorded. Age and sex standardized prevalence of hypertension according to JNC-V criteria increased from 26.9 percent in 1968 to 44.9 percent in 1996-97. In 1968, 70% of the male population were engaged in sedentary and light physical activity compared to 73.7 percent in 1996-97. High and high middle-income groups in males were 61.2% in 1996-97 compared to 37.4% in 1968. Smoking rates, however, remained unchanged, 25.4 percent men smoked in 1968 compared to 24.6 percent in 1996-97. The prevalence of hypertension has almost doubled over 30 years in Chandigarh. Unfavourable changes in prevalence of hypertension physical activity, and body fat makes this population highly vulnerable to Cardiovascular morbidity and mortality.
Shanthirani, Pradeepa, Deepa, Premalatha, Suroja and Mohan (2003) examined the prevalence of hypertension and its associated risk factors in an urban South Indian population at Chennai. The Chennai urban population study (CUPS) is an epidemiological study involving two residential areas in Chennai in South India. 1399 eligible subjects (age ≥ 20 years), 1262 (90.2%) participated in the study, subjects were classified as hypertensive using the criteria, systolic blood pressure (SBP) ≥ 140 mm Hg, and / or diastolic blood pressure (DBP) ≥ 90 mm Hg and / or treatment with anti-hypertensive drugs. Twelve-lead resting electrocardiography (ECG) was performed in 1175 individuals and peripheral Doppler studies were done in 50% of the individuals (n=631). Results indicated that prevalence of hypertension appears to be high in this urban south Indian population and this calls for urgent steps for its prevention and control

PSYCHOSOCIAL CORRELATES OF HYPERTENSION:

Ghosh and Sharma (1998) examined the role of anxiety and anger in essential hypertension and surgical orthopaedic patients (n=40 each), by administering the Hindi version of Spielberger's t-anxiety scale of STAI and anger expression (ax) scale in clinical setting. Patients of both groups i.e, E.H and surgical/orthopaedic were male, married outpatients with mean age of 46.53 and 40.38 years respectively. These patients had urban middle class
background, a minimum of high school education and no other secondary complications. The findings are when compared to the surgical/orthopaedic controls, EH patients reported not only higher trait anxiety but also higher frequency of anger regardless of the direction of anger expression. When dimensions of anger were considered, EH patients reported higher active suppression of angry feelings than their surgical/ortho counterparts. However, no significance difference was observed on aggressive behavior direct towards other people or object in the environment. This study highlights the association of negative emotions (anxiety and anger).

Sehgal (2000) examined the role of anger, anxiety, hostility, irritability and type A behaviour pattern in Essential Hypertension (EHT) and Coronary Heart Disease (CHD). Three groups of subjects (hundred each) belonging to the above-motioned groups i.e., EHT, CHD, plus a healthy group were included as subjects. Standard internationally recognized instruments were used and the earlier work was thoroughly surveyed so that a cross-cultural prospective could be evolved.

Mulli, Stieber, Wickmann, Koenig and Peters (2001) Examined the association between blood pressure, meteorology, and air pollution in a random population sample. Blood pressure measurements of 2607 men and women aged 25 to 64 years who
participated in the Augsburg Monitoring of Trends and Determinants in Cardio Vascular Disease survey were analyzed in association with 24-hour mean concentrations of air pollutants. Continuous concentrations of total suspended particulates and sulfur dioxide were associated with an increase in systolic blood of 1.79 mm Hg (95% confidence interval) (CI)=0.63, 2.95 per 90 ug/m$^3$ total suspended particulates and 0.74 mm Hg (95% CI=0.08, 1.40) per 80 ug/m$^3$ Sulfur dioxide. In subgroups with high plasma viscosity levels and increased heart rates, systolic blood pressure increased by 6.93 mm Hg (95% CI=4.31, 9.75) and 7.76 mm Hg (95% CI=5.70, 9.82) in association with total suspended particulates. The observed increase in systolic blood pressure associated with ambient air pollution could be related to a change in cardiovascular autonomic control.

Sande et al (2001) questioned 5389 adults as to any first degree family history of non-communicable diseases (hypertension, obesity, diabetes and stroke), and measured their blood pressure (BP) and Body Mass Index (BMI). Total blood cholesterol, triglyceride, uric acid, and creatinine concentrations were measured in a stratified sub samples as well as blood glucose in persons aged >35 years. A significant number of subjects reported a family history of hypertension (8.0%), obesity (5.4%) diabetes (3.3%) and stroke (14%), with 14.6% of
participants reporting any of those NCAS. Subjects with a family history of hypertension had a higher diastolic BP and BMI, higher cholesterol and uric acid concentrations, and an increased risk of Obesity. Results show that family history of hypertension, Obesity, diabetes, or stroke was a significant risk factor for Obesity and hyperlipidaemia with increase of age, more pathological manifestations can develop in this high risk group.

Light (2002) comments on the article by D. Carroll et al., which presented results of the 2nd phase of a prospective study examining BP reactivity to a mental stressor in middle aged men as a predictor of subsequent BP level and hypertension development. The framework for the study was provided by the Classic Reactivity Hypothesis. K.C. Light suggested that it is time for this hypothesis to reflect its advancing maturity and yield its place to the next generation. One of the Labeled the Gene and Environment Modulated Reactivity Hypothesis, assumes that there is substantial plasticity in the relationship between genetic factors and hypertension development.

Krause, Liang, Shaw, Sugisawa et al, (2002) examined whether three dimensions of religion (private religious practices, religious coping, and belief in the afterlife) buffer the effect of death of a significant other on change in self-reported hypertension over time. Interviews were conducted with a
nationally representative sample of people aged 60 and older in Japan at two points in time, 1996 and 1999. Complete data were available on 1,723 older Japanese (average age 69.17 yrs). Respondents were asked a series of questions about their religious belief and practices, whether a family member or close friend had died in the past year, and whether they had hypertension. The data suggest that older adults in Japan who experienced the death of a loved one but who believe in a good after life were less likely to report that they had hypertension at the follow up interview that elderly people in Japan who lost a close other but did not believe in good after life. The results suggest how one over looked dimension of religion (i.e., religious beliefs) may bolster the health of older people in the face of adversity.

Davidson, Schwartz, Sheffield, McCord et al (2002) discussed the cognitive and emotional processes that link emotional expression to blood pressure. They present preliminary data relating expressive writing to reductions in blood pressure. Finally, they discuss the potential benefits of expressive writing for patients with high blood pressure and future research directions.

Yadav, Siwach, Sharma, Yadav and Aggarwal (2002) examined 108 patients (67 males 41 females). Detailed history was taken. In 82 patient who were young hypertensives and had no
other clinical criteria for inclusion in the study, only 15 patients (18.3%) showed evidence of renal disease by radiological and imaging studies. 26 patients who had some other clinical criteria in addition to hypertension showed evidence of renal or renovascular disease in 17 patients, showing an increase of 47.1% as compared to those patients who had only hypertension. Thirteen out of these 26 patients had 2 or more than 2 clinical criteria; renal or renovascular changes being found in 12 patients (92.3%). Weinberger had found that all but 2% of hypertensive patients with abnormal bruit had subsequently been proved to be having renovascular hypertension.

**HYPERTENSION MANAGEMENT:**

Blumenthal, Sherwood, Gullette, Georgia des et al (2002) reviewed the current approaches to the non-pharmacological treatment of high blood pressure and highlights outcomes studies of exercise, weight loss, and dietary modification, and stress management and relaxation therapies. Methodological issues in the assessment and treatment of hypertension are discussed, along with possible mechanisms by which life style modification may reduce elevated blood pressure.
CHAPTER - III

Methodology
The methodology of the present study has been worked out in accordance with the objectives set in chapter I. The concept of methodology includes four aspects, namely, sample, measures, procedure and data analysis. The present study is of correlational in nature.

SAMPLE:

The sample consisted of two hundred patients. They were categorized into three main groups. Group I comprised of 70 hypertensive patients (male =30 and female=40). Group II comprised of male (54) and female (46) patients of bronchial asthma, and Group III Consisted of male (15) and Female (15) patients who have bronchial asthma and hypertension. The patients were drawn from the O.P.D and ward of cardiology center and from OPD and ward of T.B. and respiratory diseases of J.N. Medical College, A.M.U., Aligarh.

Distribution of Sample is given below:

\[ N = 200 \]

- Hypertensive patients (70)
  - Male (30)
  - Female (40)

- Bronchial Asthma patients (100)
  - Male (54)
  - Female (46)

- Bronchial Asthma and Hypertensive patients (15)
  - Male (15)
  - Female (15)
TOOLS: The present study employed the following tools.

Satisfaction With Life Scale (SWLS) (Diener, 1984), was used to measure subjective well-being of the patients. The satisfaction with life scale comprised 5 items with 7 point rating scale ranging from strongly agree to strongly disagree.

Dinner and other author (1985) have consistently shown correction coefficients of .8 and higher for short term (two weeks or two months) test retest methods. Longer term efforts, 10 weeks and 4 years, have shown fairly good results with corrections of .50 and .54, respectively.

Religiosity Scale (Decker And Broota, 1985)

The religious scale measures the extent of an individual's dependency on the supernatural being and adherence to the doctrines of one's faith. The final scale consisted of 44 items out of which 25 were positive and 19 were negative. The presence of both negatively and positively worded items is essential, for it avoids the tendency of the respondent to develop a response set, that might occur, were the items only positive or only negative. The reliability of the final scale was established using the split half technique. The items of the scale were split into two equivalent forms using the odd-even methods. The reliability coefficient of the half tests was .91 (using Pearson's product moment.)

The obtained value was corrected for length using Spearman
Brown formula and was 0.96. Thus, the reliability coefficient for the religiosity scale was 0.96 for an adult sample of subjects.

**Ego-Strength Scale**

Indian adaptation of Barron’s ego-strength Scale (Hasan, 1974) was used to measure ego-strength. The ego strength scale comprised of 32 items with the two alternative response category. The frequency of negative responses on the ego-strength scale indicate the degree of the ego-strength. The Odd-even reliability of the adapted scale is found to be .78 (corrected). The test retest reliabilities of the adapted scale were found to be .86 and .82 respectively.

**Significant Others Scale (SOS)**

The SOS developed by Power, Champion and Aris (1988), is a flexible instrument for the measurement of an Individuals perceived support. The aim of SOS is to measure emotional and practical support. In the scale all 10 items were prefaced with the phrase “To what extent can you........?” Actual support of the respondent was measured in terms of the currently applicable relationship (Spouse/Parents) on each of the 10 support functions. A 1-7 scale was used from 1-never to 7=always. The test retest correlations for the scores were all highly significant and ranged from 0.73 to 0.83. There were some preliminary validity data for the scale.
PERSONAL DATA SHEET

The personal data sheet includes the following aspects like patients name, age, sex, and occupation, Name of the disease. Family history, Smoker/Non Smoker, Blood Pressure, duration of illness, mode of treatment, and hospitalized or non-hospitalized.

PROCEDURE

The data were collected individually from the patients in the O.P.D. and wards. Before administering the tools, the investigator established rapport with the patient's and assured them that data will be used for research purpose only. The investigator helped those subjects or patients who faced difficulty in understanding some of the items in the scale. After data collection scoring was done by the investigator herself.

DATA ANALYSIS

The data were analysed with the help of some suitable statistical techniques such as Person Product Moment coefficient of correlation, partial coefficient of correlation and multiple coefficient of correlation. Pearson Product Moment correlations were computed to determine the relationship between the variables of the study among the groups.

Partial correlations were computed for partilled out or eliminating the effects of variables, that may influence the
relationship between two variables whose relationship is to be considered. Multiple coefficient of correlations were computed to determine the correlations between scores actually obtained and scores predicted on satisfaction with life scale from the three variables, Religiosity, Ego- Strength and Social Support.
CHAPTER - IV

Results and Discussion
The present study was designed to examine the impact of religiosity, ego strength and social support on subjective well being of cardiovascular disorder patients (i.e. hypertension) and respiratory disorder patients (i.e. Bronchial Asthma).

The data analysed by means of various correlation techniques are presented in the following Tables. The descriptions of the results have been given side by side. The following abbreviation are used in the description of results:

SWB-Subjective well-being
SOS- Significant others scale
SWLS-Satisfaction with life scale

Table 1. Person Product Moment correlations between subjective well-being and Religiosity Scores.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>N</th>
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<th>Hypertension</th>
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<tr>
<td>Male</td>
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<td>&lt;0.01</td>
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Table 2: Pearson Product Moment correlations between subjective well-being and Ego-Strength Scores

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<th>Subjects</th>
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<tr>
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Table 3: Pearson Product Moment correlations between Subjective well-being and Social Support Scores.

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</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>0.49</td>
<td>30</td>
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<td>&lt;0.01</td>
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</table>
Table 4: Pearson Product Moment correlations between Religiosity and Ego-Strength Scores.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>N</th>
<th>Bronchial Asthma</th>
<th>N</th>
<th>Hypertension</th>
<th>N</th>
<th>Bronchial Asthma and Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>0.13</td>
<td>30</td>
<td>0.19</td>
<td>15</td>
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</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>0.07</td>
<td>40</td>
<td>0.13</td>
<td>15</td>
<td>0.12</td>
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</table>

Table 5: Pearson Product Moment correlations between Religiosity and Social Support Scores

<table>
<thead>
<tr>
<th>Subjects</th>
<th>N</th>
<th>Bronchial Asthma</th>
<th>N</th>
<th>Hypertension</th>
<th>N</th>
<th>Bronchial Asthma and Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>0.06</td>
<td>30</td>
<td>0.20</td>
<td>15</td>
<td>0.34</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>0.32</td>
<td>40</td>
<td>0.12</td>
<td>15</td>
<td>0.03</td>
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</table>
Table 6: Pearson Product Moment correlations between Social Support and Ego- Strength Scores

<table>
<thead>
<tr>
<th>Subjects</th>
<th>N</th>
<th>Bronchial Asthma</th>
<th></th>
<th>N</th>
<th>Hypertension</th>
<th></th>
<th>N</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>54</td>
<td>r 0.30 p&lt;0.05</td>
<td>30</td>
<td>r 0.35 p&gt;0.05</td>
<td>15</td>
<td>r 0.23 p&gt;0.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>r 0.06 p&gt;0.05</td>
<td>40</td>
<td>r 0.21 p&gt;0.05</td>
<td>15</td>
<td>r 0.13 p&gt;0.05</td>
<td></td>
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</table>

Table 7: Indicating the values of partial r at .95 confidence interval in Bronchial Asthma male and female patients

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Confidence Interval</th>
<th>Female</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>r12.34</td>
<td>0.29</td>
<td>0.03 to 0.52</td>
<td>0.34</td>
<td>0.13 to 0.64</td>
</tr>
<tr>
<td>r 13.24</td>
<td>0.14</td>
<td>0.03 to 0.57</td>
<td>0.41</td>
<td>0.11 to 0.62</td>
</tr>
<tr>
<td>r14.23</td>
<td>0.45</td>
<td>0.26 to 0.67</td>
<td>0.22</td>
<td>0.02 to 0.57</td>
</tr>
<tr>
<td>r23.14</td>
<td>0.13</td>
<td>-0.14 to 0.40</td>
<td>0.07</td>
<td>-0.24 to 0.38</td>
</tr>
<tr>
<td>r24.13</td>
<td>0.02</td>
<td>-0.21 to 0.33</td>
<td>0.31</td>
<td>-0.00 to 0.62</td>
</tr>
<tr>
<td>r34.12</td>
<td>0.29</td>
<td>0.04 to 0.58</td>
<td>0.03</td>
<td>-0.27 to 0.35</td>
</tr>
</tbody>
</table>
Table 8: Indicating the values of partial r at .95 confidence interval in Hypertensive male and female patients.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>C.I.</th>
<th>Female</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>r12.34</td>
<td>0.10</td>
<td>-0.29 to 0.45</td>
<td>0.017</td>
<td>-0.24 to 0.40</td>
</tr>
<tr>
<td>r13.24</td>
<td>0.44</td>
<td>0.19 to 0.76</td>
<td>0.41</td>
<td>0.15 to 0.67</td>
</tr>
<tr>
<td>r14.23</td>
<td>0.56</td>
<td>0.33 to 0.81</td>
<td>0.52</td>
<td>0.28 to 0.74</td>
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<tr>
<td>r23.14</td>
<td>0.19</td>
<td>-0.20 to 0.58</td>
<td>0.13</td>
<td>-0.20 to 0.46</td>
</tr>
<tr>
<td>r24.13</td>
<td>0.14</td>
<td>-0.25 to 0.53</td>
<td>0.09</td>
<td>-0.24 to 0.43</td>
</tr>
<tr>
<td>r34.12</td>
<td>0.32</td>
<td>-0.07 to 0.72</td>
<td>0.19</td>
<td>-0.14 to 0.53</td>
</tr>
</tbody>
</table>

Table 9: Indicating the values of partial r at .95 confidence interval in patients of Bronchial Asthma and Hypertension

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>C.I.</th>
<th>Female</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>r12.34</td>
<td>0.20</td>
<td>-0.55 to 0.57</td>
<td>0.18</td>
<td>-0.41 to 0.68</td>
</tr>
<tr>
<td>r13.24</td>
<td>0.02</td>
<td>-0.53 to 0.59</td>
<td>0.16</td>
<td>-0.41 to 0.68</td>
</tr>
<tr>
<td>r14.23</td>
<td>0.62</td>
<td>0.05 to 0.87</td>
<td>0.03</td>
<td>-0.52 to 0.60</td>
</tr>
<tr>
<td>r23.14</td>
<td>0.49</td>
<td>0.14 to 1.12</td>
<td>0.12</td>
<td>-0.51 to 0.75</td>
</tr>
<tr>
<td>r24.13</td>
<td>0.26</td>
<td>-0.36 to 0.89</td>
<td>0.014</td>
<td>0.61 to 0.64</td>
</tr>
<tr>
<td>r34.12</td>
<td>0.07</td>
<td>-0.55 to 0.70</td>
<td>0.127</td>
<td>-0.50 to 0.75</td>
</tr>
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</table>
Table 10: Indicating the values of Multiple R.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>N</th>
<th>Bronchial Asthma</th>
<th>N</th>
<th>Hypertension</th>
<th>N</th>
<th>Bronchial Asthma and Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>p</td>
<td>R</td>
<td>p</td>
<td>R</td>
<td>p</td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
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<td>&lt;0.05</td>
<td>30</td>
<td>0.71</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>0.58</td>
<td>&lt;0.05</td>
<td>40</td>
<td>0.76</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Results presented in Table 1 indicate that the a positive relationship existed between subjective well-being and religiosity scores among male \( r=0.29, p<.05 \) and female \( r=0.41, p<.01 \) bronchial asthma patients, whereas in male and female patients suffering from hypertension and bronchial asthma and hypertension, significant correlations did not emerge between SWB and religiosity.

Significant positive correlation coefficients were found to exist between SWB and ego-strength scores among male \( r=0.29, p<.05 \) and female \( r=0.40, p<.01 \) bronchial asthma patients, and male \( r=0.53, p<.01 \) and female \( r=0.45, p<.01 \) hypertensive patients.

Except in the case of female patients suffering from bronchial asthma and hypertension significant relationship was not found to exist between scores obtained an SWLS and SOS, whereas in the remaining group of subjects significant positive correlation
coefficients were found to exist between subjective well-being and social support.

Significant relationship did not emerge between religiosity and ego-strength among male and female patients, suffering from various diseases.

All the correlation coefficients were found to be non-significant between scores obtained on religiosity scale and SOS among male and female patients of bronchial asthma, hypertension and bronchial asthma and hypertension groups.

Significant positive correlation coefficient was found to exist between scores obtained on SOS and ego-strength for male bronchial asthma patients, whereas in the remaining group of patients significant relationship did not exist between the scores obtained on both the variables (cf Table 6).

The significant positive relationship between subjective well-being and religiosity among male and female bronchial asthma patients imply that patients who experience high level of subjective well-being are also having high religious orientation. Bronchial asthma patients who evaluate their lives as satisfying may be due to that they perceived the same amount of religious orientation. Strong religious orientation helps recovery from asthma. Bronchial asthma patients with strong religious faith may indeed be more able to cope
with changes in their physical health and experience high level of satisfaction. Some research suggests that religious involvement is favourably associated with measures of physical health such as high blood pressure (Levin & Vanderpool, 1989). The well-being of bronchial asthma patients might be more due to their religious involvement. Recent studies revealed that “religious people seem to be better off psychologically than non-religious people or religiosity improves the quality of life.(Poloma & Pendelton, 1991).

Significant positive relationships exist between subjective well-being and ego-strength among male and female bronchial asthma and hypertensive patients. These positive correlation coefficients suggest that the well-being is influenced by ego-strength. Subjective well-being reflects a stable and consistent phenomenon that is theoretically and empirically related to personality constructs. Ego-strength of patients help in maintaining the level of satisfaction, and in affect may provide such patients of bronchial asthma and hypertension with a sense of hope that things will turn out all right regardless of their suffering and thus foster greater motivation to achieve satisfaction with life. Furthermore, bronchial asthma and hypertensive patients perceived satisfaction with life with in the domain generated by their ego-strength.

The significant positive relationship also exist between
subjective well-being and social support among male bronchial asthma and hypertensive patients. Social support of family members and friends is an integral element of mental and physical health. Social support promotes well-being. Social support of the family members may provide male patients with a sense of hope that things will turn out all right regardless of their illness and thus, foster greater motivation among them to maintain well-being. The findings of Branda et al. (1980) and Cohen & Wills (1985) have suggested that social support contributes to positive adjustment, personal development and increased well-being in general.

Significant relationships were not found to exist between religiosity and ego-strength, and religiosity and social support among male and female patients of bronchial asthma, hypertension and bronchial asthma and hypertension. That is religiosity did not emerge as a significant correlate of ego-strength and social support. Patients who are not religious, lack social support and have low level of ego-strength may be at increased risk of stress-related disorders, bronchial asthma and hypertension.

Male bronchial asthma patients exhibited significant relationship between social support and ego-strength. This indicates that have strong ego and also strong social ties. People with a strong network of social ties ten to have a high level of ego strength.
Male and Female bronchial asthma and hypertension patients and male bronchial asthma and hypertension patients exhibited significant relationship of subjective well-being with all the three variables of religiosity, ego-strength and social support. Thus, it is implied that all these variables are closely linked with the subjective well-being of these patients. People with firm religious beliefs, strong social interactions and high level of ego-strength are likely to have a greater sense of subjective well-being.

The partial correlations between subjective well-being and religiosity, when ego-strength and social support variables were partialled out, we get a partial r12.34 of 0.29 and 0.34 as against an r12 of 0.29 and 0.41 among male and female bronchial asthma patients. The partial correlations between SWB and ego-strength, when religiosity and social support were partialled out we get an r13.24 of 0.14 and 0.41 as against an r13 of 0.29 and 0.40 among male and female bronchial asthma patients. The partial correlation existed between SWB and social support, when variables of religiosity and ego-strength were partialled out (r14.23=male 0.45, female 0.22 against r14 of male 0.49, female 0.32). The partial correlations did not exist between religiosity and ego-strength when the variables of SWB and social support were partialled out among male and female bronchial asthma patients. The partial correlation
existed between religiosity and social support ($r=24.13=0.31$ against $r24=0.32$) among female bronchial asthma patients. The partial correlation between ego-strength and social support existed ($r34.12=0.29$ against $r34=0.30$) among male bronchial asthma patients (cf Table-7).

The partial correlations between subjective well-being and religiosity, when ego strength and social support variables were partialled out, we get a partial $r12.34$ of 0.10 and 0.017 as against an $r12$ of 0.09 and 0.09 among male and female hypertensive patients.

The partial correlations between SWB and ego-strength, when religiosity and social support were partialled out we get a $r13.24$ of 0.44 and 0.41 as against an $r13$ of 0.53 and 0.45 among male and female hypertensive patients. The partial correlation existed between SWB and social support when variables of religiosity and ego-strength were partialled out (male $r14.23= 0.56$ and female 0.52 against $r14$ of male 0.62 and Female 0.55). The partial correlation between religiosity and ego-strength when Subjective well-being and social support were partialled out ($r23.14$) were found to be 0.19 for male and 0.13 for female hypertensive patients. The partial correlation existed between religiosity and social support when SWB and Ego-strength were partialled out ($r24.13= male 0.14$ and female 0.09 as against $r24$ of male =0.20 and female 0.12). Partial
correlations between Ego-strength and social support when SWB and religiosity were partialled out (r34.12) were 0.32 for male and 0.19 for female hypertensive patients as against r34 of 0.35 for males and 0.21 for female hypertensive patients, (Cf. Table 8).

The partial correlations between SWB and religiosity, when ego-strength and social support variables were partialled out, we get a partial r12.34 of 0.20 for male patients of bronchial asthma and hypertension group as against an r12 of 0.02.

The partial correlation existed between SWB and Ego-strength, when religiosity and social support variables were partialled out, we get a partial r13.24 of 0.02 as against an r13 of 0.04 for male patients of bronchial asthma and hypertension group. The partial correlation between SWB and social support when religiosity and ego-strength were partialled out (r14.23) was 0.62 as against an r14 of 0.59 for male patients of bronchial asthma and hypertension group.

The partial correlation between religiosity and ego-strength, when SWB and social support were partialled out, we get a partial r23.14 of 0.49 for male patients of bronchial asthma and hypertension group. The partial correlation between religiosity and social support when SWB and ego-strength were partialled out, we get a partial r24.13 of 0.26 for male bronchial asthma and hypertensive patients as against an r24 of 0.34.
The partial correlations between these variables were found to be insignificant for the female patients belonging to bronchial asthma–hypertension group (Cf Table 9).

Multiple coefficient of correlations indicated that subjective well-being scores were correlated with religiosity, ego-strength and social support among male (R=0.57, p<05) and female (R=0.58, p<05) bronchial asthma patients.

Multiple R existed when the subjective well-being scores were correlated with religiosity, ego-strength and social support scores among male (R=0.71, p<01), female (R=0.76, p<05) hypertensive patients.

In male patients suffering from both bronchial asthma and hypertension diseases, the subjective well-being scores were correlated with religiosity, ego-strength and social support scores (R=0.62, p<05), whereas for female patients subjective well being scores were not correlated with religiosity, ego-strength and social support scores (R=0.26, p>05).
CHAPTER - V

Conclusions, Implications, and Suggestions for Future Research
Conclusions:

The findings of the present study have led to certain conclusions. These are summarized as under:

- The present research has contributed significantly the idea that the patients who have high religious involvement have greater sense of well-being. Individuals who have strong faith are able to cope better with their illness and those who are religious are likely to live longer than those who profess no religious beliefs.

- The present research has highlighted the important role played by family and social support in the alleviation of respiratory and cardiovascular disorders. Persons having strong family and social ties are able to face health problems more effectively.

- Findings of the present study imply that ego-strength affects the well-being of bronchial asthma and hypertensive patients. Patients with high levels of ego-strength exhibit greater sense of well-being.

- Psychosocial variables like social support, or marital - family stability and ego-strength, positive attitudes and emotions are associated with physical health, religious involvement and with well-being.

- It is therefore, concluded that Psychosocial variables like, religiosity, ego-strength and social support are closely linked with
the well-being. Therefore it is necessary to strengthen and enhance the level of these variables in the case of respiratory and cardiovascular disorder patients.

Implications

- A set of psychosocial variables like religiosity, ego-strength and social support is the best approach to study the subjective well-being of psychosomatic disorder patients. This can be helpful for medical or health professional to look forward to the psychological aspects of these diseases.

- Research suggests that the association of religious involvement and physical health might be more closely tied to the psychosocial resources.

- The findings of the present study helps in understanding that religion can bestow on believers a contentment and resilience in the face of misfortune that is due to the hope provided by faith, with which modern medicine and psychotherapy can still, even after thousands of years, simply not compete.

- This study also helps the medical or health care professional to understand the role of various psychosocial factors in the causation of these diseases like bronchial asthma and hypertension.
• This study also helps in understanding the role of religiosity in healthy living or well-being of the patients.

Suggestions for Future Research

Despite of various research work on psychosocial variable on the diseases, there are many other areas that needed to be explored further in order to gain better understanding of the phenomenon.

• Relationship between other variables, like hopefulness, optimism, and various aspects of well-being.

• Role of various holistic approaches like yoga and meditation in the management of bronchial asthma and hypertension should be investigated.

• Future researches should investigate the influence of religiosity on well-being of the people in general.

• Further research should also examined the role of various psychosocial factors as the causative factors in the development of stress-related disorders.

• Further research should also explore the impact of people’s illness on the well-being of their family members.

• Researchers may use more reliable measures of multiple dimensions of religious involvement e.g. public religious involvement, private religious activities, religious beliefs, religious motivation etc.
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Appendices
Personal Data Sheet (PDS)

Name of the Patient: .................................. C.C. NO. ..............................................
Age: .................................. Occupation: .................................................................
Sex: .................................. Marital Status ..............................................................
Name of the Diseases: Bronchial Asthma / Hypertension: ..............................................
Family History: ................................. Smoker/Non Smoker: ..................................
Blood Pressure: .......................................................... ..................................................
Duration of Illness: .......................................................... ..............................................
Hospitalized / Non–Hospitalized: .......................................................... ..................................
Mode of Treatment: Allopathic: ................................. / Unani: ..................................
Ayurveda: .......................................................... / Homeopathy: ..................................
Satisfaction with Life Scale (SWLS)

Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open in responding.

7- Strongly agree          6-Agree          5-Slightly agree
4-Neither Agree nor Disagree 3- Slightly Disagree 2-Disagree
1-Strongly disagree.

___ In most ways my life is close to my ideal.

___ The conditions of my life are excellent.

___ I am satisfied with my life.

___ So far I have got the important things I want in life.

___ If I could live my life over, I would change almost nothing.
Religiosity Scale: (RS)

Instructions: Below are given certain items which are meant for measuring the attitude of people towards religious orientation. You are required to give your answers and opinions by putting a (√) tick mark on any one of the following five categories given against each item.

<table>
<thead>
<tr>
<th>Strongly Agree (SA)</th>
<th>Agree (A)</th>
<th>Undecided (U)</th>
<th>Disagree (D)</th>
<th>Strongly Disagree (SD)</th>
</tr>
</thead>
</table>

1. Heaven and Hell do not exist
   These are creations of the mind.  
2. A good man is one who has complete faith in GOD.  
3. The evolution of universe is a scientific fact. It was not a creation of God.  
4. The miracles/events reported by the Gurus/Prophets messengers are the absolute truth only man fails to recognize them.  
5. It is necessary to believe and follow
ones religious faith or the other, in order to live a good life.

6. People who strive for the good of all being need no religion.

7. The soul is immortal and belongs to God.

8. Everyone’s destiny/fate is in God’s hand.

9. Religious books are merely good literature, they have no other significance.

10. God is the creator and giver therefore one’s life should be guided in accordance with Gods Plan.

11. God created the universe for a specific purpose.

12. Deep faith in God helps one to overcome all crises.

13. The crises and problems of life are God’s way to test the faith of man.
14. Unquestioning acceptance of the written word has made man a slave of tradition.

15. It is important to pray to God in the way prescribed in one's religious faith.

16. Every person should have deep faith in some supernatural force higher than oneself, whose decisions one should not question.

17. A pious and God fearing person will go to heaven.

18. A man without a religion is like a student without a teacher.

19. There is a supreme being or God who controls the destiny of man.

20. Gurudwaras/Temple/Churches/Mosques have become centers of Intrigue and polities.

22. Praying a sign of weakness and helplessness.

23. Prayer is a means of communicating with God and inviting his grace.

24. Religion is the only force which restrains man from committing immoral acts.

25. Social discriminations in our society have their roots in religion.

26. The holy books of my faith are the result of divine inspiration.

27. Gods messengers on earth are Prophets, Saints and Gurus.

28. Happiness can not be gained through prayers, sacrificial offerings.

29. Religion prevents the development of rationality.

30. Religion is the only means of making man aware of his own essential goodness.
31. Belief in God leads to inaction and acceptance of injustice.
32. Every man needs some religious faith to help him meet the problems of life.
33. In every religion people with Leadership qualities were proclaimed as saints and prophets.
34. Man prays only for selfish reasons.
35. Pilgrimage to holy places of worship of one's faith is necessary for all believers.
36. Man is the creator of his own destiny.
37. Churches, temples and mosques - religious places of worship serve as meeting places for people belonging to the same faith. They have only social significance.
38. Casually or improperly performed prayer is a disrespect to God.
39. Faith in God makes man more human.

40. Religious places of worship play no role in the spiritual and moral development of man.

41. Man is capable of ruining his own life without the intervention of any supreme being.

42. Gross injustice have been committed in the name of God.

43. Love and compassion for the creatures of the universe is the highest form of religion.

44. There is force or power beyond the understanding of modern science.
Ego-Strength Scale (ESS)

Instructions:
Here are some statements regarding the way you behave, feel or act. Please read each statement carefully and put ‘T’ in the left hand margin against the statement which is true for you and ‘F’ against the statement which is false for you. Work quickly and do not spend time over any statement. PLEASE NOTE THAT THIS IS NOT A TEST OF INTELLIGENCE AND THAT THERE ARE NO RIGHT OR WRONG ANSWERS.

Statements:

( ) 1. I feel weak all over much of the time.

( ) 2. I have a cough most of the time.

( ) 3. I have good appetite.

( ) 4. I have diarrhea once a month or more.

( ) 5. My sleep is fitful and disturbed.

( ) 6. I feel unable to tell any one all about myself.

( ) 7. I brood a great deal.

( ) 8. I frequently find myself worrying about something.

( ) 9. I have met problems so full of possibilities that I have been unable to make up my mind about them.

( ) 10. Sometimes some unimportant thought will run through my mind and bother me for days.
Often I cross the street in order not to meet some one I see.

I dream frequently about the things that are best kept to myself.

Prophets and ‘Avtars’ could perform miracles.

I have had some unusual religious experiences.

I believe my sins are unpardonable.

I do many things which I regret afterwards.

I do not like to see women smoke.

I have had very peculiar and strange experiences.

I have strange and peculiar thoughts.

I have had blank spell in which my activities were interrupted and I did not know what was going on around me.

When I am with people I am bothered by hearing very queer things.

At times I have fits of laughing and crying that I cannot control.

Parts of my body often have feelings like burning, tingling, crawling and like ‘going to sleep’.

My plans have frequently seemed so full of difficulties that I have had to give them up.

I am easily downed in argument.

I find it hard to keep my mind on task or job.

I sometime feel that I am going to pieces.

I feel tired a good deal of time.
29. I like to cook.

30. Dirt frightens or disgusts me.

31. I am afraid of finding myself in a closed or small places.

32. I have often frightened in the middle of the night.
(Significant Others Scale) SOS

Directions:

Below are given certain items referring to support functions. You are required to rate relationship with your parents/spouse on each of the 10 support functions on a 7-point scale. You have to rate the relationship that you feel is currently applicable in terms of the actual levels of support.

1. Always
2. Very frequently
3. Frequently
4. Occasionally
5. Rarely
6. Very rarely
7. Never

1. To what extent can you trust, talk to frankly and share feelings with.  

2. To what extent can you lean on and turn to in times of difficulty.  

3. To what extent can you get interest, reassurance and a good feeling about yourself.  

4. To what extent can you get physical
comfort.

5. To what extent can you resolve unpleasant disagreement if they occur.

6. To what extent can you get financial and practical help.

7. To what extent can you get suggestions, advice and feedback.

8. To what extent can you visit them or spend time with them socially.

9. To what extent can you get help in an emergency.

10. To what extent can you share interests and hobbies and have fun with.