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## Positive and Negative Affect on Quality of Life: A Review

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As we promote the message of current year WHO theme – “Depression – Lets talk”, Positive affect (PA) and Negative Affect (NA) has to be understood in detail. In this competitive world, as a health care professional, understanding the science behind depression and well-being of a person is important in clinical diagnosis of the both. The effect of positivity and negativity in our personnel life comprises of various emotional outbursts. Both has significant effect on our quality of life and has an impact on our health. This brief review tries to explore the positive and negative effect on quality of life.

**KEYWORDS:** Positive affect (PA), Negative affect (NA), Quality of life

### INTRODUCTION

Briefly, Positive Affect (PA) shows the extent to which a person feels enthusiastic, active, and alert. High PA is a state of high energy, maximum concentration, and pleasurable engagement, whereas low PA is reported by sadness and lethargy. In contrast, Negative Affect (NA) is a general appearance of subjective distress and unpleasurable engagement that subsumes a variety of negative mood states, including anger, contempt, disgust, guilt, fear, and nervousness.

#### Positive and negative affect

PA and NA have been found to relate to different grades of variables, with NA (but not PA) related to stress and coping, health complaints and frequency of unpleasant events, and PA (but not NA) related to social activity and satisfaction, and frequency of pleasant events.<sup>1</sup>

While PA and NA are considered separate dimensions, and both are associated with quality of life in the expected directions and in the presence of each other– the effect of PA was attenuated in the presence of NA, reflecting the more dominant role for NA in relation to quality of life. The attenuation may be expected given the observed correlation between PA and NA. While the observed correlation was in the range of low to moderate.<sup>2</sup> This size of effect is unlikely to result

in collinearity problems. Collinearity refers to relationships among the independent variables and is used to indicate that one predictor is an exact linear combination of the others. Near collinearity arises when there is a high degree of association between independent variables and may result in inaccurate estimates of regression coefficients, standard errors and hypothesis test statistics.<sup>3</sup>

Not all studies find such correlations between PA and NA and this most likely reflects the adoption of a longer time frame of "last year" with the Bradburn scale, as affectivity scales have been reported to be more reliable over longer time frames<sup>3</sup> such that the scales should represent relatively fixed personality dispositions rather than recent life events.<sup>4</sup> The relationship of personality, particularly negative affect, and well-being has been explained through a dynamic equilibrium model involving both personality and life events<sup>5</sup> whereby life events may alter well-being temporarily before personality traits draw people back to their usual level of life events and well-being. Other studies looking at cognitive functioning have found NA to be more strongly related to self-appraisal of cognitive functioning than PA.<sup>6</sup> Affectivity in terms of PA and NA has been suggested as a mediator of the link between

outcome expectancies related to optimism and pessimism and psychological adjustment in terms of depressive symptoms and life satisfaction.<sup>7</sup> Self-esteem has also been shown to be strongly negatively correlated with neuroticism/NA and moderately to strongly related to extraversion/PA.<sup>8</sup>

### **Subjectivity of quality of life measures and affectivity**

It may be expected that more subjective indices such as the OHIP subscales psychological discomfort and psychological disability would have stronger associations with NA than less subjective indices such as physical disability and functional limitations.<sup>9</sup>

### **Symptom perception**

One main path of symptom perception of common physical symptoms has been identified as involving more NA via a stronger tendency to selective attention. A study of chronically ill patients found that optimism did not tend to bias their perceptions of their health status but that positive efficacy expectancies encouraged self-care behavior.<sup>10</sup> Another study of self-reported symptoms among asthmatics found that patients with high NA were more influenced by suggestion than patients with low NA.<sup>11</sup>

However, the tendency to overestimate the likelihood of ambiguous symptoms as being indicative of serious illness appears to be unique to hypochondriasis and not attributable to high NA.<sup>12</sup> While experience of oral symptoms may vary between individuals, some specific oral symptoms such as toothache are considered more likely to influence quality of life and alter behavior through the seeking of professional care than other symptoms such as sore gums or sensitive teeth.<sup>13</sup> There is also evidence of specific relationships between oral health status and reported impact on quality of life, such as number of teeth and chewing ability, missing front teeth with self-esteem and going out, as well as fewer functioning teeth and more decayed teeth with aesthetic dissatisfaction, altered eating, diminished communication and pain.<sup>14</sup> Personality, through affectivity, may influence quality of life measures through symptom perception, whereby high NA individuals are more sensitive to health conditions and therefore more likely to perceive and/or complain about health concerns resulting in worse

quality of life scores and possibly inflated health-related complaints. More subjective indices of quality of life may therefore be more prone to being influenced by personality variables such as affectivity. This may warrant the need to control for personality factors, but also provides additional insight into the understanding how health conditions influence functioning and well-being. There is also evidence that positive mental states are more than the absence of symptoms, and may play an independent role in health outcomes.<sup>14</sup>

### **CONCLUSION**

PA and NA both accounted for additional variance in quality of life scores indicating that personality factors have independent effects on self-ratings of health-related quality of life. Furthermore, both PA and NA has its the effects on oral health status, socio-economic status, and dental visiting pattern indicating that understanding the PA and NA is useful to figure out its role in quality of life.

### **REFERENCES**

1. Watson D, Clark LA, Tellegen A. Development and validation of brief measures of positive and negative affect: the PANAS scales. *J Pers Soc Psychol* 1988;54:1063-70.
2. Martin P, Bateson P. *Measuring behaviour. An introductory guide* Cambridge: CUP; 1986.
3. Kleinbaum DG, Kupper LL, Muller KE, Nizam A. *Applied regression analysis and other multivariable methods* CA: Duxbury Press; 1998.
4. Warr P, Barter J, Brownbridge G. On the independence of positive and negative affect. *J Pers Soc Psychol* 1983;44:644-51.
5. Ormel J, Lindenberg S, Steverink N, Vonkorff M. Quality of life and social production functions: a framework for understanding health effects. *Soc Sci Med* 1997;45:1051-63
6. Seidenberg M, Taylor MA, Haitner A. Personality and self-report of cognitive functioning. *Arch Clin Neuropsychol* 1994; 9:353-61.
7. Chang EC, Sanna LJ. Optimism, pessimism, and positive and negative affectivity in middle-aged adults: a test of a cognitive-affective model of psychological adjustment. *Psychol Aging* 2001;16:524-31.

8. Watson D, Suls J, Haig J. Global self-esteem in relation to structural models of personality and affectivity. *J Pers Soc Psychol* 2002;83:185-97.
9. Kressin NR, Reisine S, Spiro A 3rd, Jones J. Is negative affectivity associated with oral quality of life? *Community Dent Oral Epidemiol* 2001;29:412-23.
10. de Ridder D, Fournier M, Bensing J. Does optimism affect symptom report in chronic disease? What are its consequences for self-care behaviour and physical functioning? *J Psychosom Res* 2004;56:341-50.
11. Put C, Van den Bergh O, Van Ongeval E, De Peuter S, Demedts M, Verleden G. Negative affectivity and the influence of suggestion on asthma symptoms. *J Psychosom Res* 2004;57:249-55.
12. Marcus DK, Church SE. Are dysfunctional beliefs about illness unique to hypochondriasis? *J Psychosom Res* 2003;54:543-7.
13. Gift HC. Oral health outcomes research – challenges and opportunities. In *Measuring oral health and quality of life Volume Chapter 3*. Edited by: Slade GD. Chapel Hill: University of North Carolina, Dental Ecology; 1997.
14. Huppert FA, Whittington JE. Evidence for the independence of positive and negative well-being: Implications for quality of life assessment. *Br J Health Psychol* 2003;8:107-22.

**Cite this article as:**

Saheer AP, Mariette TM, Majid SA. Positive and Negative affect on quality of life: A Review. *Int Healthcare Res J* 2017;1(5):7-9.

**Source of support:** Nil, **Conflict of interest:** None declared

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