Critically discuss the evidence to suggest that positive affect is associated with health outcomes

Positive affect (PA) is defined as feelings that reflect a level of pleasurable engagement with the environment such as happiness, joy, excitement, enthusiasm and contentment. There are two types of PA – state PA (short term positive emotions) and trait PA (long term positive emotions).

Studies can utilise self-reported ratings of different mood items to assess PA. A commonly used measure is the positive mood scale from the Positive and Negative Affect Schedule (PANAS). PANAS is a questionnaire made up of two 10-item mood scales which consist of words that describe different emotions which can then be related to a number from 1-5 depending on how the individual feels over a certain period of time (1=very slightly or not at all, 2= a little, 3= moderately, 4=quite a bit, 5=extremely). In this model high PA is a state of high energy and concentration (e.g attentive, interested, alert and enthusiastic) whereas negative affect (NA) is a state of general distress (e.g guilty, hostile and irritable). The authors suggest that because of the independence of their scales, these items are pure markers of NA and PA. However, an issue with literature is whether PA and NA are in fact independent factors or bipolar ends of the same scale. If PA and NA are bipolar ends of the same construct, benefits of PA may merely reflect the absence of NA rather than the presence of positive feelings. Alternatively, should the two be independent, PA could provide benefits independent of NA levels. A problem with PANAS is that it includes adjectives that are not typical of mood items such as strong, determined and active, and excludes low activated moods such as calm, content, and relaxed, as well as many common PA adjectives such as happy, cheerful and joyful.

Typical studies that can be used to show if positive affect links to health outcomes include mortality studies, morbidity studies as well as, studies involving self-reported health outcomes.

Cohen et al (1995) found that individuals with high trait NA reported more symptoms than would be expected from their underlying disease. Cohen et al (2003) found that individuals with high trait PA reported fewer and less severe symptoms. This suggests that high PA results in better self-reported health outcomes among patients.

Mortality studies are prospective studies of defined populations where PA is assessed at the onset of the study and participants are followed for a specified number of years. Danner et al (2001) conducted a study whereby PA was evaluated by coding autobiographical writing samples from a group of nuns when they were in their early twenties. The greater the number of positive emotion words and sentences, the greater was the probability of being alive 60 years later. In contrast, the number of negative emotions (NA) reported was not associated with mortality. Therefore, PA was found to be linked to longevity whereas NA was not. Maier and Smith (1999) examined how subjective well being influenced mortality in a sample of older individuals by utilising the PA and NA scales of PANAS. Lower levels of well-being (low PA, high NA) were associated with greater mortality risks in comparison to higher levels of well-being (high PA, low NA). Overall, these two studies found that high PA decreased mortality. However, a study by Stones et al (1989) found that high PA increased mortality. They examined state and trait PA of older nursing home residents by measuring levels of happiness at that moment as well as over the past month on a scale of 1-7. The validity of mortality studies are dependent on the adequacy of the baseline measure of health since inadequate measurement would allow the possibility that being healthier at baseline contributed to both greater PA at baseline and to subsequent longevity.