

Original Article

Implications of Social Support and Socio-Economic Status on Perceived Health and Wellbeing of Psychiatric Patients

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Abstract

The recent global economic recession has promoted increasing concern about the impact of social economic factors as risk factors for mental disorders. This study therefore examined socio-economic factors as determinants of health and wellbeing of psychiatric patients in State Hospital Adeoyo, Ringroad, Ibadan. This study adopted a cross-sectional survey design. The research was conducted in State Hospital Adeoyo, Ringroad, Ibadan. A total number of 71 psychiatric participants were purposively sampled from the hospital to participate in this study. Standardized scales were utilized in eliciting relevant information relating to the participants of the study. Both descriptive and inferential statistics were employed in the data analysis of the study. Multiple regression and ANOVA were adopted for the hypotheses testing at 0.05 level of significance. Social support, income and educational status jointly predicted and accounted for 18.8% of the variance in health status of psychiatric patients in State Hospital Adeoyo [$F_{(3,67)}=5.156$; $P<.05$]. Social support ($\beta=-.338$; $P<.05$) and educational status ($\beta=-.231$; $P<.05$) emerged as significant predictors of health status among psychiatric patients while income ($\beta=.069$; $P>.05$) did not predict health status among psychiatric patients. Social support, income and educational status did not jointly predict subjective wellbeing of psychiatric patients in State Hospital Adeoyo [$F_{(3,67)}=1.787$; $P>.05$]; while only educational status ($\beta=.245$; $P<.05$) emerged as significant predictor of subjective wellbeing among psychiatric patients. Age [$F(1, 60)=6.194$; $P<.05$] had significant main effect on the subjective wellbeing of psychiatric patients in State Hospital Adeoyo, with participants above 35 years reporting more positive subjective wellbeing that participants below 35 years [$t(69)=-2.600$; $P<.05$]. Both the main effect of sex [$F(1, 60)=.307$; $P>.05$] and the interaction effect of age and sex [$F(1, 60)=.814$; $P>.05$] on subjective wellbeing of psychiatric patients in State Hospital Adeoyo were not significant. Related discussions, implications and recommendations were made based on the study outcomes.

Keywords: Social Support, Socio-Economic Status Health Wellbeing Psychiatric Patient

Introduction

The recent global economic recession has promoted increasing concern about the impact of social and economic factors as risk factors for mental disorders. There have been theoretical assumptions about the link between health, wellbeing and socio-economic factors. For instance social causation posits that adversity, stress, and reduced capacity to cope related to low income

increase the risk of development of health comorbidities of mental illness while the social selection hypothesis suggests that individuals with mental illness have a predisposition to declining socioeconomic status due to possible genetic factors, hospitalizations related to mental illness, and/or loss of work.

These theories have been debated but there is limited empirical support for these assumptions,

especially from a local perspective. The few related studies conducted in Nigeria (e.g. Adedimeji, Alawode and Odutolu, 2010; Okhakume and Aroniyiaso, 2017; Osamor, 2015) have generally focused on social support and patients' wellbeing without acknowledging the socio-economic status of their participants. Thus, there is need for this gap in literature to be bridged by conducting empirical research into the significant associations among health, wellbeing and socio-economic factors among mentally ill patients. It is against this background that the study examined socio-economic factors influencing health and wellbeing of psychiatric patients in State Hospital Adeoyo, Ringroad, Ibadan.

Health is defined broadly as a person's mental or physical condition. However, among mentally ill patients, the dimension of physical health is emphasized. Therefore, health among mentally ill patients is defined as the physical condition and absence psychiatric comorbidities. It is well known that mentally ill persons face serious challenges regarding their health (American Psychiatric Association, 2013). In recent years, there has also been an increased interest in physical health among mentally ill persons (De Hert, Cohen, Bobes, Cetkovich-Bakmas, Leucht, Ndeti, Newcomer, Uwakwe, Asai, Möller, 2017, Mitchell, Delaffon, Vancampfort, Correll, De Hert, 2012). One reason for this growing interest is due to the fact that mentally ill persons' lives are considerably shorter than those of the general population (Colton & Manderscheid 2006). Life expectancy for persons diagnosed with schizophrenia is about 25 years less than a healthy person (Wahlbeck, Braddick & Gabilondo, 2011). Still, a major part of this group is affected by the metabolic syndrome, many even before the age of 30 (Meyer & Stahl 2009). Cardiovascular risk factors, such as obesity, tobacco use, diabetes, and dyslipidemia occur frequently (McEvoy, Meyer, Goff, Nasrallah, Davis, Sullivan, Meltzer, Hsiao, Scott & Lieberman, 2005), and together they contribute to a great risk of somatic illness and metabolic syndrome.

Subjective well-being is defined by Snyder and Lopez (2002) as a person's affective evaluations of his or her life. These evaluations include emotional reactions to events as well as personal judgements

of satisfaction and fulfillment. Subjective well-being among mentally ill persons is a construct that reflects an understanding and appraisal of their life. These appraisals may be primarily cognitive (e.g. life satisfaction) as well as affective, consisting of pleasant or unpleasant emotions that individuals experience (e.g. happiness and depression). Subjective well-being combines both the frequency and intensity of pleasant emotions; and considers both socio-economic and long term levels of affect and satisfaction. Veenhoven (1991) pointed out that wellbeing describes feelings of happiness and gratification of bio-psychological needs. Many researchers have defined well-being, but as Gasper (2002) points out, the term well-being is a concept or idea referring to whatever is assessed in an evaluation of a person's life situation or 'being'. Summarized, it is the description of the state of the individual's life situation which centers on the individual's personal judgements.

Health and wellbeing can be influenced by various social and economic factors; these factors, which can be synergistic or oppositional to each other, may pose considerable challenges or act as buffers for individual trying to maintain their health. Therefore, researchers who study health behaviors should consider these social and economic factors. In this study, health and wellbeing among mentally ill persons would be assessed in relation to social and economic factors. Social factors include human norms and interactions that affect lifestyle while economic factors include financially driven aspects of one's life. The social factor of interest in this study is social support while the economic factors of interest in this study are indices of socio-economic status which include income, educational status, occupation

Social support is defined as (i) the perceived qualitative functions performed for the individual by significant others, including emotional and instrumental support; and (b) the perceived quantitative structure of one's social ties, including the number and frequency of contacting friends and family, marital and parental status, and group membership (Cohen, 2008). Within social support research, a line of interest has developed from studies revealing how support influences health behaviour, which may influence overall health status such as mortality risk. Research has shown

how social relationships can influence health behaviours such as: compliance with medical regimens, help seeking behaviour, infant feeding practices, smoking, and weight loss (Heaney & Israel, 2007). Research indicates that individuals who report receiving more support for specific health related behaviours, such as avoiding alcohol or tobacco, are more likely to engage in the desired behaviours, compared to those who do not receive such support (Adler & Matthews, 2004). Other research examining the relationship between general measures of social support and various health behaviours has shown a consistent finding of high levels of total social support being associated with healthy behaviour choices (Cobum & Pope, 2014).

Socioeconomic status is a complex concept that has been borrowed by medical researchers, often without due regard to its sociological inheritance. In epidemiology the concept is assessed indirectly using a variety of different measures with different implications for social and economic policy. Income, material possessions (or standard of living), occupational status, and education are the domains most commonly studied. Nevertheless, these measures are not equivalent and might have different meanings and represent different concepts of social position in different cultures. For instance, income changes throughout life while education remains comparatively “frozen” after early adulthood and educational attainments can have different meaning in different places. The association between relative or absolute income and health is among the most commonly reported in the scientific literature. However, some studies (Muller, 2002; Reading, 2000) have found that this association is weakened or disappear when controlling for other socioeconomic variables, especially education. Understanding the relation between socioeconomic status and health depends upon distinguishing these various measures and examining for independent associations with health.

A large body of scientific literature, mainly from western countries, shows that social disadvantage, especially lack of material possessions, lower income, and financial strain are associated with comorbidities of common mental disorders (Kessler 2004; Lewis, Bebbington & Brugha,

2008; Weich 2008). However, much less is known of the socioeconomic determinants of health and wellbeing among the mentally ill in non-western countries. Nevertheless most of the world’s populations live outside the western countries and it is these developing countries that experience the largest degree of socioeconomic inequality. Thus it is still unclear which socioeconomic factors, if any, are independently associated with an increased prevalence of common mental disorders and its association with health and wellbeing among the mentally ill.

Review of Related Studies

Social Support, Health and Wellbeing

Leme, Del Prette and Coimbra (2015) Evaluated the influence of family configuration, social skills and social support appraisals as potential predictors of adolescent psychological well-being. The participants were 454 adolescents aged between 13 and 17 years from nuclear, separated and remarried families. The adolescents were students in the first and second years of public high school. The data were collectively obtained in the classroom using the Social Skills Inventory for Adolescents, the Social Support Appraisal Scale and the Psychological Well-being Scale. The results indicated that family configuration is not associated with the psychological well-being of adolescents. The social skills of empathy, self-control, civility, social resourcefulness and affective approach as well as the social support appraisals from friends and family were the best predictors of adolescent psychological well-being.

Rami (2013), using two studies, investigated one possible mechanism through which social support affects emotional well-being—that is, one’s strategy of emotion regulation. Study 1 examined the influence of social support on one’s positive affect over the past two months, and whether this was influenced by one reappraising his or her emotions. Participants completed an online survey that evaluated their emotion regulation approach, social support, and well-being. Results showed that people who had more social support were more likely to experience greater positive affect, and reappraisal was a potential mechanism. Extending these results, Study 2 focused on how social support helps people cope with specific negative

experiences. Results showed that the more social support participants reported receiving, the lower their emotional reactivity to a recalled personal negative event. Interestingly, participants thinking that the event was less important to them influenced this effect. Collectively, these findings show how one's emotion regulation strategies can serve as a mechanism through which social support has an influence on emotional well-being.

Mousavi , Kalyani, Karimi, Kokabi, and Piriaee (2015) tested a model for the effect of social support on mental health considering the mediating role of problem-oriented coping strategy. In this correlation study, 95 infertile women that had referred to Fasa public and private medical centers were selected through available sampling. Participants completed Multidimensional Scale of Perceived Social Support (MSPSS), Mental Health Inventory (MHI) and Coping Inventory for Stressful Situations (CISS-21). Fitness of the proposed model was examined through structural equation modeling (SEM), using SPSS-18 and AMOS-18 software packages. The indirect effects were tested using the bootstrap procedure. Findings indicated that the proposed model fit the data properly and social support has direct and indirect effect on mental health in infertile women. The results also supported the mediating role problem-oriented coping strategy in the relationship between social support and mental health. The study results revealed that the perceived family support can have a powerful impact on how a woman experiences infertility stress, both directly and indirectly. Also, high levels of perceived support from friends can decrease women's social stress levels through the use of active-confronting coping strategies.

Costa, José Sá and Calheiros (2012) determined the predictive value of social support on health related quality of life (HRQoL) in multiple sclerosis (MS) patients. Methods: The sample is composed by 150 MS consecutive patients. We used the Medical Outcomes Study Social Support Survey to assess social support and the Health Status Questionnaire to assess HRQoL. For inferential analysis, we used the Multiple Linear Regression with stepwise selection of variables. Results: The age, basic education, psychological support and disability explains 41.6% of the

variance in physical function, 29.4% in physical performance and 30.6% in emotional performance. Age and psychological support explains 23.1% of the variance in physical function and 29.4% in vitality. Conclusion: This study demonstrated that social support is a predictor with a significant effect on HRQoL in MS.

Suldo and Huebner (2014) examined the mental health of 15- to 19-year-old youth in five cities and identified the social support correlates of mental health. A total of 2,393 adolescents aged 15–19 years in economically distressed neighborhoods in Baltimore, MD; New Delhi, India; Ibadan, Nigeria; Johannesburg, South Africa; and Shanghai, China were recruited to participate in a survey using an audio computer-assisted self-interview. Weighted logistic regression and general linear models were used to explore the associations between mental health and social supports. The highest levels of depression and posttraumatic stress symptoms were displayed in Johannesburg among females, whereas the lowest were among New Delhi females and males. The prevalence of suicidal ideation ranged from 7.9% (New Delhi female adolescents) to 39.6% (Johannesburg female adolescents); the 12-month prevalence of suicide attempts ranged from 1.8% (New Delhi females) to 18.3% (Ibadan males). Elevated perceptions of having a caring female adult in the home and feeling connected to their neighborhoods were positively associated with adolescents' levels of hope across the sites while negatively associated with depression and posttraumatic stress symptoms with some variation across sites and gender.

Asante (2012) investigated the association between age, gender, social support and the psychological wellbeing of people living with HIV and AIDS (PLHA) in Ghana. Cross-sectional data containing information on demographics, social support and psychological well-being (stress, depression, and anxiety), were collected from 107 men and women living with HIV/AIDS. To explore age group differences, participants were stratified by age (< 39 vs. 40+ years). Three anonymous self-administered questionnaires were used, namely the demographic data questionnaire, Sources of Social Support Scale, and the Depression Anxiety Stress Scale (DASS- 42). Correlation analysis revealed that social support was negatively associated with

depression, stress and anxiety. Compared with males living with HIV, women reported higher levels of stress, depression and anxiety. Female gender and low social support were significant predictors of depression and stress after controlling for selected independent variables. Older participants experienced higher levels of stress than their younger counterparts.

Okhakume and Aroniyiaso (2017) examined the influence of coping strategies and perceived social support on depression among elderly people. This study adopted cross sectional research design to examine the influence of coping strategies and perceived social support on depression among elderly people who are 60 years and above in kajola local government area of Oyo state, Nigeria. Purposive sampling technique was used systematically to select 200 elderly people that participated in the study. The result of the finding revealed that elderly people with low perceived social support reported higher depression than their counterpart with high perceived social support and it was also discovered that elderly people with low coping strategies reported higher depression than their counterpart with high coping strategies among elderly people. More so, the result of the findings depicted that, there was significant joint influence of coping strategies and perceived social support on depression. Further analysis revealed that coping strategies and perceived social support made significant independent contribution to depression among elderly people in kajola local government area of Oyo state, Nigeria.

Osamor (2015) investigated the relationship between social support for treatment compliance among hypertensive subjects in a poor urban community in southwest Nigeria. A second objective was identifying the correlates of social support in the study sample. The study was a community-based, cross-sectional and descriptive study of 440 community residents (mean age 60 years, 65.2% women) from Idikan community, Ibadan, Nigeria who had hypertension. Most subjects (~ 93%) reported receiving some social support from family members and approximately 55% reported receiving social support from friends. Social support from friends ($p < 0.0001$) but not from family ($p = 0.162$) was significantly associated with good compliance with treatment

for hypertension. Factors associated with receiving significant support from both family and friends included marital status and religion, while age and educational level were associated with receiving significant support from family members only. Gender was not significantly associated with receiving social support.

Adedimeji, Alawode and Odutolu (2010) examined the impact of social, economic, psychological and environmental factors on health and wellbeing among PHA living in southwest Nigeria. Using qualitative participatory methodology, 50 HIV positive people, 8 health personnel and 32 care providers were interviewed to explore how care and social support affect wellbeing among PHA in view of constraints to accessing antiretroviral drugs. Analysis of data used the grounded theory (GT) approach to identify themes, which are considered crucial to the wellbeing of PHA. The findings highlight several factors, apart from antiretroviral drugs, that impact the wellbeing of PHA in southwest Nigeria. These include concerns about deteriorating physical health, family and children's welfare, pervasive stigma, financial pressures and systemic failures relating to care among others. We describe how psychosocial and social support structures can considerably contribute to improving health outcomes among them because of how they affect the functioning of immune system, self-care activities and other illness behaviours.

Economic Factors, Health and Wellbeing

Brown and Gray (2014) explored the importance of the household's financial position for an individual's level of well-being. Initially, the empirical analysis, based on a large nationally representative panel survey, aims to ascertain the impact of the household's monetary financial position on overall life satisfaction and financial well-being, with the latter being measured by financial satisfaction and subjective prosperity. Taking into account monetary factors in addition to income, the results indicate that the household's level of net wealth, assets and debt are important determinants of overall life satisfaction and financial well-being. The paper also explores whether the financial situation of households in a comparison group influences an individual's overall life satisfaction and financial well-being.

The results suggest that the financial position of households in the comparison group is an important determinant of an individual's level of overall life satisfaction and financial well-being.

Taylor, Jenkins and Sacker (2011) examined whether financial capability has impacts on psychological health independent of income and financial resources more generally using a nationally representative survey. British Household Panel Survey data are used to construct a measure of financial capability, which they related to respondents' psychological health using the 12-item General Health Questionnaire. We find that financial capability has significant and substantial effects on psychological health over and above those associated with income and material wellbeing more generally. The sizes of these impacts are considerably larger than those associated with changes in household income. Furthermore having low financial capability exacerbates the psychological costs associated with unemployment and divorce.

Martos and Kopp (2012) extended the scope of previous research by analyzing the role of financial status (income and subjective financial status) on intrinsic life goals (e.g. personal growth and relationships). Examining a nationally representative cross-sectional sample of 4,841 Hungarian adults, They found that after controlling for several socio-demographic variables intrinsic goal importance was in a positive relationship with subjective well-being (SWB) and meaning in life (ML), whereas the contribution of extrinsic life goals was weak to SWB and negative to ML. Moreover, no moderation effects were found for indices of financial status, indicating that the relationship between life goals and well-being is the same for poorer and for richer respondents. Results showed that the basic assumptions of the Aspiration Index research are also valid when testing on a societal level

Several studies indicate a relationship between occupational characteristics and wellbeing. For example, occupations with meaning to the individual have a positive association with SWB (e.g. Palys and Little 1983). Additionally, McGregor and Little (1998) found that enjoyable, supported and efficient occupations were associated with a higher level of well-being,

whereas Lecci et al (1994) showed that persons scoring high on measures of depression rate their occupations as more stressful and difficult. Similarly, other studies have shown that participants whose occupations are characterized by a high level of efficacy, control, and meaning, and by low levels of stress reported a higher level of well-being (Christiansen 2000; McGregor and Little 1998; Yetim 1993). Studies found that occupations that are supported and valued by others (the community characteristic) have a positive effect on well-being (Salmela-Aro & Little 2007; Wallenius 1999; Wenzel 2000). Hence, there is considerable support, theoretically as well as empirically, for the relation between occupational characteristics and well-being.

Christiansen, Backman, Little and Nguyen (1999) explored the relationship between occupation and subjective well-being (SWB). A convenience sample of 120 adults completed a personal projects analysis, a method of rating their current goal-directed pursuits. They also completed measures of SWB and personality traits. Characteristics of personal projects were correlated with SWB scores. Multiple regression analysis was used to investigate possible predictors of well-being from among the characteristics of personal projects, personality traits, and demographic variables. The stress associated with personal projects was significantly and inversely correlated with well-being, as was project difficulty. Perceived progress in completing projects was significantly positively correlated with well-being. The strongest predictors for well-being were the composite project factors of stress and efficacy. Two personality traits, sensing and extraversion, interacted with the project dimension of stress to emerge as significant predictors of well-being. Together, these four variables explained 42% of the variance in well-being scores.

Anaby, Jarus, Backman and Zumbo (2010) proposed and tested a theoretical model for specifying the structural relationships between occupational imbalance, occupational characteristics, personality and well-being. 288 working adults completed the following questionnaires: Inter-goal Relations Questionnaire (occupational imbalance), Personal Projects Analysis (occupational characteristics), the Big

Five Inventory (personality traits) and the Satisfaction with Life Scale (well-being). Twenty-five models were tested using structural equation modeling. All the models fit the data well. Occupational characteristics, with the exception of stress, served as significant mediators between personality and well-being, yet occupational imbalance did not play a significant role across all models.

Hypotheses

1. There will be significant influence of social support and socio-economic status (income and education) on health of psychiatric patients in state hospital Adeoyo
2. There will be significant influence of social support and socio-economic status (income and education) on subjective wellbeing of psychiatric patients in state hospital Adeoyo
3. There will be significant main and interaction influence of age and gender on health of psychiatric patients in state hospital Adeoyo
4. There will be significant main and interaction influence of age and gender on subjective wellbeing of psychiatric patients in state hospital Adeoyo

Methods

Design, Sample Size and Participants

This study adopted a cross-sectional survey design. A cross sectional survey involves data collection from a specific population at a specific point in time. The focus was to empirically examine socio-economic factors influencing health and wellbeing of psychiatric patients. The research was conducted in State Hospital Adeoyo, Ringroad, Ibadan. This preference was based on the accessibility to the research participants. Convenience sampling was adopted in selecting the hospital that made up the research setting. Factors considered for the selection included proximity to the researcher, size of hospital, popularity of hospital, consent of participation from hospital management etc. However, purposive sampling (based on the eligibility criteria) was employed in the selection of the participants of the study in the hospital. This was

achieved by liaising with hospital nurses and caregivers of patients within the psychiatric unit of the hospital.

A sample size of about 71 participants was selected from the hospital to participate in this study. The potential participants were psychiatric patients. The sample consisted of both male and female participants. Majority of the participants were between ages 20 – 30 years. The mean age was 32.6 years with a standard deviation of 3.411. Male participants comprised 47.9% of the sample while 52.1% were female. Interms of their marital status, 43.7% were single, 45.1% were married, 8.4% were separated, while 2.8% were widowed. Ethnic affiliations of the participants showed that majority (91.5%) of the participants were Yorubas. Igbos comprised 7.0% of the participants while the remaining 1.4% were from other ethnic groups. No Hausa participants were involved in the study.

Majority (43.7%) of the participants had tertiary education. Participants with no formal education accounted for 15.5% of the sample, while those with primary and secondary education accounted for 9.9% and 28.9% of the participants respectively. Occupational categories to which participants belonged to included farming (14.1%), trading (23.9%), civil service (21.1%), self-employed artisans (7.0%) and medical practitioners (1.4%). The remaining 32.4% were categorized as unemployed. Finally, more than half (53.5%) of the participants earned below N20,000 as their average monthly income. Average monthly income of N21,000-N50,000 was earned by 25.4% of the participants, N51,000-N100,000 was earned by 5.6% of the participants, N101,000-N150,000 was earned by 7.0% of the participants, while 8.5% of the participants earned above N150,000.

Measures

Social Support

Social support was measured using the Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988). The scale is used to measure people's subjective evaluations of social support adequacy. It assessed the perceptions of social support adequacy from three different sources: family, friends, and significant other. One of the advantages of MSPSS is its user friendly style. It is a simple-to-use and

time-conserving scale. It uses a five point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. The scale consists of 12 items and three factors: perceived support from family, perceived support from friends, and perceived support from significant other. Each factor has four items. The reliability of the original scale was .88 as reported by its original authors.

Perceived Health Quality

Patients' health related quality of life was measured using the EQ-5D by Herdman et al (2012). The EQ-5D is a generic health related quality of life instrument consisting of five items: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each item is scored on 5-point scale: no problems (score of 1), slight problems (2), moderate problems (3), severe problems (4), and extreme problems (5). Responses to these items can be converted to a composite score for the five dimensions. The EQ-5D Index has high reliability with Cronbach alpha ranging from .75 to .81.

Subjective Wellbeing

Wellbeing was assessed using an adapted version of the Oxford Happiness Questionnaire (OHQ) by Hills and Argyle (2002). The Oxford Happiness Questionnaire uses 29 items rated on a six-point Likert-type response format (strongly disagree, moderately disagree, slightly disagree, slightly agree, moderately agree, strongly agree). However, only 15 items were selected for the study for cultural relevance. The OHQ has no time reference and instructs participants to think about how they feel in accordance with the statement "most of the time or in general." The OHQ proved to be a reliable ($\alpha = .91$) measure in a sample of 172 high school students. Construct validity was evaluated by investigating relationships between scores on the OHQ and related constructs as well as comparing these relationships with the OHI and the same related constructs (Hills & Argyle, 2002).

Results

Following the completion of the data collection, the questionnaires were coded, scored and inputted in an SPSS program for analysis. Both descriptive and inferential statistics were employed in the data

analysis of the study. Multiple regression and ANOVA were adopted for the hypotheses testing.

Hypothesis One

There will be significant influence of social support and socio-economic status (income and education) on health of psychiatric patients in State Hospital Adeoyo. This hypothesis was tested using multiple regression analysis. Results are presented in Table 1

Results from table 1 show that social support, income and educational status jointly predicted and accounted for 18.8% of the variance in health status of psychiatric patients in State Hospital Adeoyo [$F_{(3,67)}=5.156$; $P<.05$]. Further results on the independent influence of the independent variables showed that social support ($\beta=-.338$; $P<.05$) and educational status ($\beta=-.231$; $P<.05$) emerged as significant predictors of health status among psychiatric patients while income ($\beta=.069$; $P>.05$) did not predict health status among psychiatric patients. The hypothesis stated is partially supported.

Hypothesis Two

There will be significant influence of social support and socio-economic status (income and education) on subjective wellbeing of psychiatric patients in State Hospital Adeoyo. This hypothesis was tested using multiple regression analysis. Results are presented in Table 2

Results from Table 2 show that social support, income and educational status did not jointly predict subjective wellbeing of psychiatric patients in State Hospital Adeoyo [$F_{(3,67)}=1.787$; $P>.05$]. However, further results on the independent influence of the independent variables showed that only educational status ($\beta=.245$; $P<.05$) emerged as significant predictor of subjective wellbeing among psychiatric patients while social support ($\beta=.135$; $P>.05$) and income ($\beta=-.081$; $P>.05$) did not predict subjective wellbeing among psychiatric patients.

The hypothesis stated is therefore not fully supported due to the insignificant influence of social support and monthly income on subjective wellbeing of psychiatric patients in State Hospital Adeoyo.

Hypothesis Three

There will be significant main and interaction influence of age and gender on health of psychiatric patients in State Hospital Adeoyo. This hypothesis was tested using Factorial ANOVA. Results are presented in Table 3

Results from Table 3 show that age [F(1, 60)=.246; P>.05] and sex [F(1, 60)=.481; P>.05] did not have main effect on the health status of psychiatric patients in State Hospital Adeoyo. Similarly, the interaction effect of age and sex [F(1, 60)=.980; P>.05] on the health status of psychiatric patients in State Hospital Adeoyo was not significant. The hypothesis stated is therefore rejected.

Hypothesis Four

There will be significant main and interaction influence of age and gender on subjective wellbeing of psychiatric patients in State Hospital Adeoyo. This hypothesis was tested using Factorial ANOVA. Results are presented in Table 4

Results from Table 4 show that only age [F(1, 60)=6.194; P<.05] had significant main effect on the subjective wellbeing of psychiatric patients in State Hospital Adeoyo. Both the main effect of sex [F(1, 60)=.307; P>.05] and the interaction effect of age and sex [F(1, 60)=.814; P>.05] on subjective wellbeing of psychiatric patients in State Hospital Adeoyo were not significant. The hypothesis stated is therefore not fully supported. A post hoc (t-test) analysis was carried out to identify the direction of significant main influence of age on subjective wellbeing of psychiatric patients in State Hospital Adeoyo. Results are presented in Table 5

Results from table 5 show that there was a significant difference in subjective wellbeing between participants below 35 years and their counterparts above 35 years [t(69)=-2.600; P<.05]. The results imply that participants above 35 years reported more positive subjective wellbeing that participants below 35 years.

Table 1: Social and economic predictors of health status among psychiatric patients

	R	R ²	F	Sig	β	t	Sig.
Social Support					-.338	-2.954	.004
Average Monthly Income	.433	.188	5.156	.003	.069	.605	.547
Educational Status					-.231	-2.034	.046

Table 2: Social and economic predictors of subjective wellbeing among psychiatric patients

	R	R ²	F	Sig	B	t	Sig.
Social Support					.135	1.101	.275
Average Monthly Income	.272	.074	1.787	.158	-.081	-.663	.509
Educational Status					.245	2.021	.047

Table 3: Main and interaction influence of health status among psychiatric patients

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Age	1.778	1	1.778	.246	.622
Sex	3.474	1	3.474	.481	.491
Age * Sex	7.074	1	7.074	.980	.326
Error	433.151	60	7.219		
Total	3625.000	64			
Corrected Total	446.859	63			

Table 4: Main and interaction influence of subjective wellbeing among psychiatric patients

Source	Type III SS	Df	Mean Square	F	Sig.
Age	922.573	1	922.573	6.194	.016
Sex	45.758	1	45.758	.307	.581
Age * Sex	121.195	1	121.195	.814	.371
Error	8936.667	60	148.944		
Total	135865.000	64			
Corrected Total	10106.109	63			

Table 5: Age differences in subjective wellbeing

Age	N	Mean	S.D.	df	t	Sig.
Below 35years	30	40.1333	11.45526			
Subjective Wellbeing				69	-2.600	.012
Above 35 years	41	48.0294	12.68138			

Discussion

Results from hypothesis one showed that social support and educational status are significant predictors of health status of psychiatric patients in State Hospital Adeoyo. The results imply that high levels of social support received reduced the health challenges that psychiatric patients experienced. Similarly, higher educational experience also reduced the health challenges that psychiatric patients experienced. The justification for these results stem from assumptions that a significant presence of social support from family, friends and significant others helps to buffer challenges and stress levels experienced by individuals. In relation to this study, psychiatric patients generally need the presence of a caregiver in order to successfully

navigate through the treatment process. The role of the caregiver includes ensuring adherence to treatment and assisting in health challenging activities; thus, patients who receive such social support from caregivers are more likely to report less health problems than patients without adequate social support.

In line with these results, literature suggests that the critical factor in social support operating as a stress buffer is the perception that others (even one reliable source) will provide appropriate aid (Cohen, et al, 2008). In this view, the belief that others will provide necessary resources may bolster one's perceived ability to cope with demands, thus changing the appraisal of the situation and lowering its effective stress (Thoits,

1986). Belief that support is at hand may also dampen the emotional and physiological responses to the event or alter maladaptive behavioral responses (Spiegel, Bloom & Kraemer, 2009). Cutrona and Russell (2010) proposed that social support is effective in reducing the effects of stressful events only in so far as the form of assistance matches demands of the event.

There is substantial evidence that the perceived availability of social support buffers the effect of psychological distress, depression, and anxiety (Cohen et al, 2008; Kawachi & Berkman, 2001). For example, it has been found that both student and adult samples reported more symptoms of depression and of physical ailments during various ailments but that these associations were attenuated among those who perceived that support was available from their social networks (Uchino, Cacioppo & Kiecolt-Glaser, 2016). When types of perceived support were broken down, emotional support worked in the face of a variety of types of stressful events, whereas other types of support (e.g., instrumental, informational) responded to specific needs elicited by an event.

The most striking evidence for stress buffering in the physical health realm is reported in a prospective study of Swedish patients aged 50 years and over (Goodwin et al, 2011). Those with high numbers of stressful life events in the year before the baseline exam were at substantially greater risk for mortality over a seven-year follow-up period. However, this effect was ameliorated among those who perceived that high levels of emotional support were available to them. In contrast, perceived emotional support made no difference for those with few stressful events. Social integration did not act as a stress buffer. Beyond perceptions, the actual receipt of support could also play a role in stress buffering. Support may alleviate the impact of stress by providing a solution to the problem, by reducing the perceived importance of the problem, or by providing a distraction from the problem. It might also facilitate healthful behaviors such as exercise, personal hygiene, proper nutrition, and rest (Cohen et al 2008).

The significant influence of educational status on the health status of psychiatric patients could stem from the impact of knowledge levels about healthy

living. Attainment of higher levels of education increases experience and exposure to best practices for healthy living and reduction of health challenges. For instance, a university graduate is more likely to understand the negative consequences of smoking in detail; while a less educated person might have a vague understanding of such negative consequences of smoking. Therefore, in relation to this study, highly educated psychiatric patients are more likely to have partaken in health enhancing activities due to their knowledge of such activities, which therefore decreases health challenges.

There is large body of empirical evidence to support the claim that there is a positive relation between education and health. In their survey of Wolfe and Zuvekas (2007) found a positive relation between one's education and one's own health status; a positive association between schooling and the health status of one's family members (in particular on one's children); and a positive contribution of schooling to the efficiency of (consumer) choices (i.e. on smoking and on the use of health care). The influence of poor health on educational attainment is not limited to its physical manifestations. For example, psychiatric conditions in adolescence are associated with diminished probabilities of successfully making important educational transitions such as high school completion, college entrance conditional on high school graduation, and college completion conditional on college entrance (Kessler et al. 2005; Miech et al. 2009).

Externalizing disorders (problems with control, attention, and conduct) appear to be more important for earlier educational transitions while internalizing disorders (depression and anxiety) play a stronger role in college entrance and completion (Kessler et al. 2005). The literature suggests three possible mechanisms for the significant relationship between education and attainment: (1) poor health may proxy for disadvantaged parental socioeconomic position, (2) poor health may be linked to poor educational outcomes through its effect on academic performance and cognitive development, (3) poor health may operate through poor psychosocial adjustment with peers and school.

Results from hypothesis two suggested that educational status significantly predicted subjective wellbeing of psychiatric patients in State Hospital Adeoyo. The results imply that attainment of higher education provides an avenue for positive perceptions of subjective wellbeing. The plausibility of this result may stem from the ability of highly educated patients to be in a better position to understand the prognosis of their medical condition and are therefore able to adjust accordingly; with reduced worries and anxieties. Such highly educated patients are therefore more receptive and optimistic towards treatment options and outcomes; which would translate into positive perceptions of wellbeing.

Socioeconomic status (SES) has now been increasingly acknowledged as the “fundamental cause” of disease and mortality because higher SES will lead to a wide range of material and social resources that help to avoid health risks and minimize the consequences of health problems (Phelan & Link, 2005). For instance, SES may influence risk factors such as health behaviors, access to health care and psychosocial stress (e.g., Adler et al., 2002). Among indicators of SES, education forms a unique dimension. It precedes occupation, earning, and wealth, and contributes to a variety of merits such as developing individuals’ abilities to accumulate human capitals and psychosocial resources, making it a particularly important determinant of health (Adler and Newman, 2002; Phelan and Link, 2005).

Differences in educational attainment are the root cause of health disparity because education indicates human capital (Mirowsky and Ross, 2008). Human capital refers to cognitive skills, habits, and abilities that can be used to control and direct one’s life. Based on the human capital theory, education can directly and indirectly improve health by triggering and increasing effective functioning within individuals, which helps to develop various psychosocial resources, health habits, and other abilities that are essential for individuals to achieve a better life. Social wellbeing could be considered as one of such psychosocial resources and abilities that are related to education as well as individual health. Better educated people tend to think logically, rationally, and consistently, see many sides of an issue, thus

view individual well-being to be contingent upon the development of society as a whole. Accordingly, they may value more social solidarity, social responsibility, social development, and social coherence, which in turn, may enhance other individual psychological resources and benefit their overall health and wellbeing (Ross and Zhang, 2008).

Results of hypothesis three which found no influence of age and gender on the health status of psychiatric patients in state hospital Adeoyo, imply that the health status of the study participants were not a function of age and gender differences. The justification of this result is based on the fact that psychiatric conditions are not an age or gender based ailment; therefore individuals of all ages and sexes could experience mental ailments. There is however a consensus among researchers that mental health and its disorders are determined by multiple and interacting social, psychological and biological factors which determine the prevalence, onset and course of mental and behavioral disorders. These include social and economic factors, demographic factors such as sex and age, and family environment (Farrer et al, 2008).

Some studies (Fone, et al, 2007, Holzinger et al, 2012) argue that females express more psychopathological phenomena, others consider that those conditions are more present in males, although there are also considerations that both genders suffer equally but have different problems. A very frequently asked question is what is the source of the existing differences? A final answer still does not exist but the most often discussion is concerned with whether the difference is determined by biological or psychological factors. There are also studies (Kaneko & Motohashi, 2007) that have found that all the differences are determined by social experiences. Within the discussion on social causes there are statements that male and female problems are a result of exposure to significantly different life circumstances and stresses while other consider both genders face the same experiences but with different reactions to them (Gold, 1998).

The final hypothesis of the study found that age had a significant main influence on subjective wellbeing. The results indicated that older participants reported more positive perceptions of

subjective wellbeing. Three broad explanations for high subjective wellbeing in old age are typically emphasized. The first addresses the stabilizing influence of personality and adaptational processes (Deaton, 2007): changing life circumstances may change SWB for a while, but over time, SWB may fall back to its stable—or baseline—level, determined by personality traits. The second explanation focuses on a greater use among elderly of accommodative strategies, such as downward adjustment of needs, aspirations, and comparison standards (Frijters & Beatton, 2012). These strategies promote well-being by fostering smaller aspirations-achievement gaps among elderly than middle-aged adults (Baird, Lucas & Donnellan, 2010; Schilling, 2006).

A further explanation focuses on gains in competencies to regulate emotional experience. Gerontological theory and research maintain that with advancing age, because people perceive boundaries on their time, they become more and more motivated to regulate their emotional experience, i.e. to maximize positive affect and minimize negative affect (Mroczek & Spiro, 2005). Older adults, for example, tend to drop or distance themselves from less intimate relationships and increase their emotional investments in relationships with significant others (George, 2006). With age there seems to be an increased favoring of positive over negative material even at the level of attention and memorial processing: older people, more than younger adults, attend to and remember positive information and memories better than negative ones (Cheng, 2012).

Implication and Recommendations

Results of this study give a triangulated understanding about the promotion of health and well-being in mental health services. The academic discipline of social and welfare services in clinical settings is developing evidence-based interventions to improve well-being. This complements the results emerging from this study about the role of social support and other economic factors that aid recovery from mental illness, which provide ecologically valid insights into the processes by which people experiencing mental illness can develop a purposeful and meaningful life. The implications for health professionals are therefore invested in these findings, such that, more

emphasis on the patients' own goals and strengths with integration of interventions which promote well-being into routine clinical practice. In addition, a more societally-focused role for professionals should be envisaged, in which a central part of the job is to influence local and national policies and practices that impact on well-being of mental patients. Based on the results obtained from this study, the following specific recommendations are proffered;

Firstly, caregivers of the psychiatric patients are often the closest form of social support available for the patients. Thus, there is need for caregivers of mental health patients to be educated on the importance of quality caregiving to the recovery of their wards. This can be achieved by making available psycho-educative modules for caregivers of psychiatric patients which could be incorporated into the treatment process. Such interventions would boost the quality of caregiving services rendered for psychiatric patients, while educating caregivers on different strategies to cope with the stress of caregiving.

Secondly, the emergence of educational status as a significant predictor of wellbeing among psychiatric patients suggests that effort should be put into increasing the knowledge base of psychiatric patients, in relation to their mental health problems. For instance, more educated patients are more likely to understand the prognosis of their ailments more than less educated patients. Thus, more educated patients are likely to exhibit optimism than their counterparts, which has implications for their subjective wellbeing and treatment outcomes. It is therefore necessary for positive information about the mental health conditions to be communicated to the patients, especially among less educated patients, so as increase their knowledge base and boost optimism towards treatment options and outcomes.

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