SOCIAL SUPPORT, PSYCHOLOGICAL WELLBEING AND CARDIOVASCULAR DISEASES
SOCIAL SUPPORT

The term 'Social Support' refers to the help people receive from family, friends and society in time of need. Social Support is a mediating factor or a variable that acts as a buffer against the adverse effects of life stress. Social Support and Social Networks protect the individual against disease and aid in recovery by providing a buffer against stress. Having Close Others to rely upon during stressful experiences makes it less likely that people will cope ineffectively and thus have a negative psychological or health outcome (JOHNSON and SARASON, 1970; LIN SIMEONE, ENSEL and KUO, 1979). However, CASSEL (1973), CAPLAN (1974) and MECHANIC (1974) have observed that Social Networks serve multiple functions in helping one adjust to the demands concerning what is expected of them, feedback regarding their behaviour, assistance with tasks and rewards for appropriate behaviours.

Social Support has been defined in several ways. COBB (1976) has defined Social Support more specifically as information that leads individuals to believe that they are cared for and loved, are esteemed and valued, and belong to a network of communication and mutual obligation. These three areas of information include 'Esteem Support, Emotional Support and Community Support.'

SCHAEFER et al. (1981) also identified three dimensions of Social Support: Emotional support, which involves intimacy and has to do with
receiving reassurance; Tangible support or the provision of direct aid and services; and Informational support, which includes advice concerning solutions to one’s problems and feedback about one’s behaviour.

LAZARUS and FOLKMAN (1984) defined Social Support as what an individual draws on in order to cope. THOITS (1986) viewed Social Support as a source of coping assistance e.g. advice and encouragement from a confidant may increase the likelihood that a person will rely on logical analysis, information seeking or active problem solving in times of crisis.

PSYCHOLOGICAL WELL BEING

It is often said that mental health is a full and harmonious functioning of the whole personality which gives satisfaction to the person and is beneficial to the society. It is a positive concept and not mere absence of disease. General well being is part of this positive mental health. Though the subjective feeling of well being is difficult to fathom and measure, the concept continues to be useful in mental health research. Subjective well being is now the focus of intense research attention (CAMPBELL et al. 1976; DIENER and DIENER 1995). Subjective well being is a person’s evaluations to his or her life either in terms of life satisfaction (cognitive evaluations) or affect (ongoing emotional reactions). VERMA & VERMA (1989) defined Psychological Well-Being as the subjective feeling of contentment, happiness, satisfaction with life experiences and of one’s role in the world of work, sense of achievement, utility; belongingness and absence of distress, dissatisfaction or worry.

Well Being is an ongoing process not an intermittent prescription. It is predicted on a person’s active involvement in behaviour and life style choice
that will empower them to live full responsible rewarding lives in an extremely complex world.

Longman’s Dictionary of **PSYCHOLOGY and PSYCHIATRY** (1984) defines mental health as a state of mind characterized by emotional well-being, relative freedom from anxiety and disabling symptoms and a capacity to establish constructive relationships and cope with ordinary demands and stress of life. From this perspective, the primary purpose of promoting wellness is to reach high levels of physical, psychological and emotional fitness to increase resistance to both minor illness and life-threatening disease. By and large, good health enables the society to lead productive life, physically, socially and financially. Health and pursuit of well being is the basic right of every individual and should be the motive of everyone. A number of correlates of subjective well being have been examined e.g. personality variables such as self esteem (**CAMPBELL, et al 1976**), income (**VEENHOVEN, 1991**) and Social Support variable such as family satisfaction (**CAMPBELL, et al 1976**).

**REVIEW OF RELATED STUDIES**

Psychological Well Being and mental health have long been known to play a positive role in health. Psychological Well Being has been associated with self actualization, maturity and continued growth (**RYFF, 1989**). Psychological Well Being in some theories has been identified with happiness and life satisfaction. It is logical therefore, to expect healthy individuals to score significantly higher than individuals suffering from Coronary Heart Disease and Essential Hypertension.
There is a growing body of evidence suggesting that supporting personal relationships are associated with greater psychological adjustment (CRANER, 1991 AND HENDERSON AND BROWN, 1988). However, due to the problems of realistically manipulating Social Support, most of the research in this area is of a non-experimental nature. Consequently the causal nature of the observed association is difficult to ascertain. However, a few prospective studies have compared the size and direction of the cross-legged coefficients between Support, adjustment and health and found the association between earlier support and later adjustment is more positive than not. (CRANER 1988, 1990, KRAUSE, LIANG and YAMOTI 1989).

In any case several studies exist, some using more credible measures of Social Support that strongly suggest that Social Support functions as a moderator of the negative effects of life stress (BROWN and HARRIS, 1978; COBB, 1976; DE ARAJUO et al., 1973; EATON, 1978; NUCKOLIS et al., 1972; SLATER and DEPUE, 1981; TURNER, 1981). Studies by ANESHENSEL and STONE (1982), LIN et al. (1979), SCHAEFER et al. 1981, WILLIAMS et al. (1981) have found that life events and Social Support make independent contributions to stress-related adjustment and health whereas others suggest that Social Support functions to reduce the debilitating consequences of experiencing stressful events and promotes mental health. There is extensive evidence for the role of Social Support in Stress resistance (COHEN AND MCKAY, 1984; COHEN & WILLS, 1985; THOITS, 1985).

Some investigators have proposed that an important aspect of Social Support is its influence on the coping strategies individuals engage in under
stress. Social Support protects people from damaging effects of Stress through its effects mediating appraisal and coping processes (LAZARUS and DELONGIS, 1983; LAZARUS and FOLKMAN, 1984). Holahan and Moos (1987) in a series of longitudinal studies found that individuals with more personal and social resources were more likely to rely on approach coping and less likely to use avoidance coping.

There is fairly consistent evidence that perceived availability of Support moderates the effects of Stress on subsequent physical illness (Wallston et al. 1987).

STROGATZ and JAMES (1986) in studying Social Support and Hypertension among Blacks and Whites in rural southern community, USA on a randomly selected 2,050 adult residents found that Blacks were more likely to have low levels of both two types of Social Support-instrumental and emotional. Low emotional support was unrelated to the prevalence of Hypertension. In unadjusted analyses, low instrumental support was associated with increased Hypertension for both races. After controlling other variables like blood pressure, the association no longer held for Whites but remained statistically significant for Blacks. Further analyses revealed that these results were specific to low income Blacks.

SHISANA and CALENTANO (1987) while studying the relationship between Chronic Stress, Social Support and Coping styles to health among Namibian refugees found that when Social Support was high, the relationship between length of stay in exile and all three health outcomes was substantially reduced. When Social Support was low, the relation between stress and poor outcomes was high.
YATES (1995) investigated the psychological characteristics related to arterial Hypertension and smoking on 2039 men and women between 25 to 60 years of age and established a relationship between coronary risk factor and psychosocial characteristics particularly social and psychological adaptation. The findings of the above study can be useful for planning future studies of psychological features of individuals with arterial Hypertension and smoking as coronary risk factors as well as choice of psychological intervention methods.

SULLIVAN and POERTNER (1986) while studying the mental health consumers perspective of Social Support and life stress found that for the mental health consumers, there was no meaningful relationship between Social Support variables and the criterion variables. However, the long term mentally ill were found to have small social networks. The authors opined that reducing loneliness by itself can be a valuable outcome of service for the population.

RYFF (1989) studied the Social Support and Psychological adjustment to Chronic Coronary Heart Disease using Johnson’s behavioural system model and found that the quality of Social Support or nurturing is the major factor predicting cardiac crippled behaviours of dependency following Myocardial Infarction (MI). The variables of Self-esteem, Anxiety, Depression and perceptions of functional capacity were identified as variables affecting choices such as return to work and adherence to the regimen and the behavioral outcome of dependency following MI.

HILDINGH et al., (1994) in studying the experiences of Social Support among participants in Self-help groups related to Coronary Heart Disease found that 84 percent of participants knew about risk factors; all group members had
changed their attitudes in some way concerning their lifestyle and 65 percent thought they had changed their daily activities as a consequence of the group participation. Most participants had experienced Social Support (about 82 percent) and their own ability to provide support (7.1, on a scale range 0-10).

In Self-help groups layman support is the most effective kind of support implied the results of this study. The results therefore suggest that future research and clinical planning of rehabilitation of people with Coronary Heart Disease, Self-help groups must be given worthy consideration both from human and economic point of view.

SCHNEIDER et al. (1986) studied the effect of Social Support, disability, coping with stress and personality markers in patients with subjective chronic aural tinnitus and a clinical control group. The following hypotheses were tested in 32 patients with chronic tinnitus and and 30 patients of a comparable clinical control group: tinnitus patients differ concerning (I) the perception of Social Support (II) a disposition to psychosomatic diseases (III) Coping with stress and (IV) Certain personality traits. Results showed that the tinnitus patients statistically perceived less Social Support and more Social Stress compared to the control group. They also showed significantly poorer results in coping with stress. Additionally a disposition to psychosomatic disorders increased, so that conflicts arising expressed themselves in various functional diseases.

Perceived availability of Social Support has also been associated with immune function. A study of 256 elderly adults by THOMAS et al., (1985) found that blood samples from persons reporting they had confiding
relationships proliferated more in response to PHA than samples from those without confiding relationships. Similar results were found in a study of 23 spouses of patients with Cancer (GOMER et al., 1993). Better immune response among supported persons could not be explained by greater depression or more numerous stressful life events among those with less Social Support. GLASER et al., (1982) found that medical students reporting more available Social Support produced more antibodies in response to four Hepatitis B vaccination than those reporting less support. HOLLIS (1992) investigated 48 hemophiliac patients with HIV virus for five years and found that those who reported less access to emotional support at baseline showed a greater decline in T-helper cells over the course of the study than those with stronger support system. There were no differences between groups in number of symptoms of AIDS or in rates of mortality.

Despite a large, rich literature on Social Support, most models focus on how Social Support affect individual outcomes e.g. Well-Being, Health, Adjustment to Stress (COYNE and DELONGIS, 1986) and generally ignore the interpersonal context in which Social Support occurs. Among those who study interpersonal relationship, Support between parties has been identified as a primary component of close relationships (HOLLIS, 1992) and more specifically some suggest Social Support in the key mechanism in relationship maintenance (BARBEE, 1990; LEATHAM and DUCK, 1990). One is in no doubt however about the positive role of perceived, tangible social support in health maintenance and disease prevention. The same is being investigated in the present study i.e. role of Social Support and Psychological Well Being in Cardiovascular disease.