

# SOCIAL ORDER AND MENTAL HEALTH: A SOCIAL WELLBEING APPROACH

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*In this paper we have tried to identify the relationships between the social order and some dimensions of health, taking as a framework the well known theoretical position of Durkheim. We define the social order as belonging to the world of our perception, experience and attribution. From this point of view the social order emerges as strongly related to the dimensions of the social wellbeing concept (social integration, social acceptance, social contribution, social actualization and social coherence). Two clear findings emerge from our data: those with a positive image, good experiences and an optimistic attributional style in relation to their social life also present high self-esteem, life satisfaction, wellbeing, and are willing to become involved in solving community problems, and those whose perception, social experience and attribution regarding the future is negative are also liable to depression, anomie, helplessness and negative affect.*

**Key words:** Social order, Health, Social wellbeing, Positive Psychology.

*En este artículo hemos querido abordar las relaciones entre el orden social y algunos aspectos de la salud, tomando como marco de referencia una de las más conocidas propuestas teóricas de Emile Durkheim. Hemos partido de una concepción del orden social no como un hecho en sí, sino como un hecho percibido que se refleja en las cinco dimensiones del bienestar social (integración social, aceptación social, contribución social, actualización social, y coherencia social) para desde ahí analizar sus relaciones con algunos componentes de la salud. Los datos apoyan de manera diáfana que la percepción, la experiencia y la atribución de características positivas a las cinco dimensiones el bienestar social auguran alta autoestima, satisfacción con la vida, sentimiento global de bienestar, implicación en los problemas sociales y afectos positivos. Por el contrario, las experiencias negativas mantienen relaciones muy estrechas con depresión, anomia, afectos negativos e indefensión.*

**Palabras clave:** Ordenamiento social, salud, bienestar social, psicología positiva

## STUDY ONE

“Health is a state of physical, social and psychological wellbeing, and not simply the absence of illness”. This definition, repeated ad infinitum since 1948, when it was adopted as its own by the World Health Organization (WHO), and although essentially sidelined by a large proportion of the disciplines traditionally responsible for the study of health, has taken on a new profile in the wake of two developments: on the one hand, the shift from a health model bound up with illness and focused on the presence within the subject of physical or psychological symptoms to a model revolving around the presence of indicators and conditions that promote and facilitate wellbeing, and following on from this, the realization that such a state of wellbeing can only apply

to subjects within a particular set of socio-historical coordinates. The idea of a subject suspended in a vacuum, a biomedical subject within a biological psychiatry (Pérez, 2003, p. 13), propagated by traditional Clinical Psychology, is pure fiction. Such a subject does not exist: he would lack “humanity” (Johann F. Herbart), she would have no higher mental structure (Vygotsky), he would be incapable of developing as a person in the psychological sense of the term (Mead), she would lack identity, according to the proposals of Festinger and Tajfel. In a Psychology that claims to respond in a valid way to the challenges of today’s world it is essential to take on board a simple assumption which enjoys solid theoretical and empirical support: that health is a state of wellbeing of a subject belonging to a socio-historical context.

A concept of health revolving around conditions that promote wellbeing was what had been promised by Positive Psychology (Snyder & López, 2002). In its early form, and without the need to make it explicit, it fully embraced the WHO philosophy on making its goal the realization of “a change in the approach of

The original Spanish version of this paper has been previously published in *Clínica y Salud*, 2006, Vol 17. No 1, 7-29

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Psychology with a view to moving from an exclusive preoccupation with remedying life's setbacks and wrong turns to an interest in also constructing positive conditions" (Seligman & Csikszentmihalyi, 2000, p. 5) capable of ensuring us the presence of fully adequate levels of wellbeing in the physical, social and psychological dimensions of our existence. "Many people think Psychology is that speciality that deals basically with people's problems," complain Avia and Vázquez, (1998, p. 21), making an urgent plea for the study of positive emotions. In short, Psychology must become a science of positive subjective experience, of positive individual traits and of positive social institutions, to provide a route for increasing quality of life and a tool for preventing pathologies when life becomes hard for us and the world around us loses meaning. References to subjective experience, to individual traits and even to positive emotions are fairly commonplace in our field, but the presence of social institutions as an ingredient of a model of positive health represents a noticeable qualitative leap. "A Positive Psychology must take into consideration positive communities and positive institutions," insist its authors (Seligman & Csikszentmihalyi, 2000, p. 8), an interesting demand which, unfortunately, has been overlooked in the subsequent development of a Positive Psychology whose culmination, according to its authors (Seligman, Steen, Park & Peterson, 2005), has been the classification of 6 virtues and 24 strengths of character. Positive communities and institutions have been diluted, leaving individuals isolated from the environment. We are back to square one: the protagonist of health or of mental disorder is a subject suspended in a vacuum.

In spite of this, the link between mental health and the positivity or negativity of institutions and communities continues to serve as a frame of reference which, given its status as a model that acknowledges the socio-historical subject, we cannot renounce, because it is the framework that permits us to challenge the notion of the biomedical subject, the heir of biological psychiatry (Pérez, 2003). This was indeed the theoretical key to Durkheim's important work "Suicide", one of the crucial texts in the history of the social sciences, and from which Psychology, both clinical and non-clinical, could still learn so much. The broad lines of Durkheim's proposal can be summarized in the following points: a) mental phenomena necessarily have social causes, and therefore constitute collective phenomena; b) these causes revolve around the "moral constitution" of societies, and manifest themselves as

tendencies of the group that penetrate irremediably into individuals; c) these would be currents of collective sadness and melancholy (morbid alterations of society) that invade the consciousness of individuals from outside: "social states are, in a sense, exterior to the individual" (Durkheim, 1928, p. 343); d) these currents are the fruit of social organization, that is, of the way individuals associate with one another, of their relational models and patterns; e) when social organization and social order are incapable of achieving "sufficient integration to maintain all their members dependent upon them," when society prevents the individual from "sustaining the bond with it" and feeling solidarity with it, mental health runs the risk of breaking down once and for all (Durkheim, 1928, p. 418). Lack of social integration, then, being identified as one of the reasons for the mental alteration that leads to mental disorder, "the only way of remedying this ill is to provide social groups with sufficient consistency to hold on more firmly to the individual, and to allow him or her, in turn, to remain united to them" (Durkheim, 1928, p. 418).

Durkheim's position is widely known, and as far as the relationship between social class and mental health is concerned, the classic contributions of Faris and Dunham (1939), from the distinguished Chicago School, of Hollingshead and Redlich (1958), and more recently of Belle (1991), provide a firm basis for the psychosocial approach to mental health, which is indeed represented, albeit somewhat timidly, in current Spanish Psychology (Álvaro, Torregrosa & Garrido, 1992; Barrón & Sánchez, 2001; Sánchez, Garrido & Álvaro, 2003). It is significant, moreover, that the central concepts and parameters dealt with in these last three works (those of social support, social integration and anomie) take Durkheim as their starting point. The psychosocial perspective attempts to reappraise the study of the relationships between some manifestations of health and certain components of the social order, though incorporating crucial features that distance it from the kind of deterministic holism that claims the essential prevalence of the "social" (the moral state of society) over the individual, so as to move nearer to positions of a marked socio-historical flavour, revolving around people's feelings, beliefs and experience with regard to certain aspects of social order, reality and relations. The unit of analysis has shifted from the linear (the social as independent variable at all times and in all places) to the relational (the social as mediator) to an individual-world relationship with distinctly Vygotskian overtones.

The article we present here is modestly intended to

make a contribution to this tradition, but with its own peculiarity: in addition to recovering the context on referring to the subject, we aim also to recover the concept of wellbeing as a framework for considering health. And we do so on the basis of two reasons: first of all, because the study of wellbeing constitutes the *raison d'être* of Psychology as a science (Miller, 1969), and secondly, because the concept of wellbeing is epistemologically removed from that ideology of illness which has dominated the study of health in Psychology, whose protagonist is a subject suspended in a vacuum. Research on wellbeing, however, frequently includes indicators such as social contact (Diener, 1994) and interpersonal contact (Erikson, 1996), complemented by social resources (Veenhoven, 1994). In this context it would be manifested in positive relations with others (Ryff & Keyes, 1995; Keyes, Shmotkin & Ryff, 2002), in active patterns of friendship, in social participation (Allardt, 1996), and so on. Wellbeing concerns us, as we have already mentioned, as the central indicator of health, and it is here that the reflections of Avia and Vázquez (1998) and, above all, the proposal of Corey Keyes, emerge as especially elucidatory. From the illness model, subjects can be considered mentally healthy if they have been free of a major depression syndrome for the previous year, but “from the health perspective an individual should be considered healthy if he or she presents high levels of social wellbeing – for example, if he or she feels well integrated in the community” (Keyes & Shapiro, in press). It is not the same to be free of problems as it is to be happy, in line with the argument convincingly developed by Avia and Vázquez (1998) in the first chapter of their work on “intelligent optimism”. This has been the framework in which Keyes (1998; 2002) has situated his proposal on social wellbeing, to which we have paid particular attention in previous works (Blanco & Díaz, 2004; Blanco & Díaz, 2005). Keyes’ proposal makes constant use of two references: on the one hand, Durkheim’s perspective as set out in “Suicide”, and on the other, the need to consider a new health model (Keyes, 2005), the Complete State Model of Health, which is underpinned by the following thirteen dimensions or symptoms of mental health: a) *positive affect*: cheerfulness, serenity, calm and love of life; b) *life satisfaction*: happiness or satisfaction with life overall or domains of life; c) *self-acceptance*: positive attitudes toward oneself and past life and conceding and accepting positive attitudes towards oneself and one’s past and acceptance of the varied aspects of self; d) *social acceptance*: positive

attitude towards others while acknowledging and accepting people’s differences; e) *personal growth*: self-confidence and openness to new experiences and challenges; f) *social actualization*: belief in the potential of people, groups and societies to evolve or grow positively; g) *life goals*: holding goals and beliefs that affirm the existence of a life full of meaning and purpose (*purpose in life*); h) *social contribution*: feeling that one’s life is useful to society and the output of one’s own activities are valued by or valuable to others; i) *environmental mastery*: capacity to manage complex environments, and to choose or manage and mould environments to suit needs; j) *social coherence*: interest in society or social life; feeling that society and culture are intelligible, somewhat logical, predictable, and meaningful; k) *autonomy*: capacity for self-direction that is often guided by one’s own socially accepted and conventional internal standards, and resistance to unsavoury social pressures; l) *positive relations with others*: capacity for empathy and intimacy; m) *social integration*: sense of belonging to a community, from which one derives comfort and support.

Positive social health, then, would be closely related to these areas of social life, such that: a) people would be healthier insofar as they had a deep-rooted sense of belonging and solid social bonds and support networks; b) levels of health would also be higher in those who trust both others and themselves, and accept themselves as they are, taking on board without over-dramatization the positive and negative aspects of their life; c) those who lived their life without letting themselves be led by social pressures and/or conventions would have a health advantage; d) more robust mental health would be enjoyed by those who felt useful to the community; e) the healthiest people, claims Keyes (1998, p. 123), trust in the future of society, acknowledge its potential for growth and trust in being able to benefit from it, and f) conceive their life and the world as being meaningful and having purpose.

Starting out from these assumptions and following some of these proposals, our initial goal here is to analyze, in a first study, the possible relationship between indicators of social wellbeing (opinions, perceptions and attributions with the help of which people manage their interpersonal and social world) and some other aspects of health (depression, self-esteem, visits to the doctor, perceived health) or of social life (anomie, social action, etc.). In a second study we consider the rest of the dimensions proposed in Keyes’ Complete State Model of Health in order to explore its

behaviour in relation to the variable “number of visits to the doctor”.

## METHOD

### *Participants and procedure*

Participants in the present study were 445 volunteers (236 men and 209 women) aged between 18 and 58 ( $M = 33$ ,  $SD = 14$ ). As regards the socio-economic and educational characteristics of the sample, 5% reported an income (for the family unit) of under 12,000 euros a year, 21% reported an income of between 12,000 and 20,000 euros, 43% indicated a figure of 20,000 to 40,000 euros and 31% declared earnings of over 40,000 euros a year. As far as educational level was concerned, 7% had attended school up to age 13 and 48% up to age 18, 25% had a degree or equivalent from higher education, and 19% had postgraduate qualifications. The study was presented as a research project on the importance of different personality traits, beliefs and attitudes in the global assessment of health. After being informed that all the information collected during the study would remain anonymous and confidential, participants received a booklet containing two blocks. The first of these comprised, in the following order, the social wellbeing scales, the single-item wellbeing scale, the psychological wellbeing scales, the life satisfaction scale, and the positive and negative affect scales. The second block included the scales of anomie, perceived neighbourhood safety, contribution, perceived limitations, self-esteem, depression, social action, recent social action and perceived health, and a question about the respondent's number of visits to the doctor over the last year. Participants took as long as they needed to complete the questionnaire.

### *Measures*

*Social wellbeing.* We used Keyes' Social Wellbeing scales (1998), recently translated into Spanish (Blanco & Díaz, 2005). This instrument is made up of five scales (social integration, social acceptance, social contribution, social actualization and social coherence), which display good internal consistency, with Cronbach's values of between 0.83 and 0.69. Participants responded to the items using an ordered categories response format with scores ranging from 1 (totally disagree) to 5 (totally agree).

*Wellbeing.* Despite the methodological problems arising from the use of these scales, we decided to use a single-item measure of global life satisfaction based on an adaptation proposed by Keyes, Shmotkin and Ryff

(2002) of Cantril's (1965) scale. The basic reason for including this measure is that variants of this scale have been used in numerous studies (Andrews & Robinson, 1991), producing very interesting results from the theoretical point of view. Moreover, in a range of research the scale has shown good psychometric properties (Keyes, Shmotkin & Ryff, 2002). Participants responded to the task of assessing their life over the last few years in a global manner by means of a response scale with scores ranking from 0 (worst life possible) to 5 (best life possible).

*Life satisfaction.* We used the life satisfaction scale by Diener, Emmons, Larsen and Griffin (1985). This scale, made up of five items, shows excellent psychometric properties and was validated in a sample of adolescents by Atienza, Pons, Balaguer and García-Merita (2000), and more recently with a sample of pregnant women and new mothers (Cabañero et. al., 2004). In our own study the scale displayed very good internal consistency ( $\alpha = 0.86$ ). Participants responded to each one of the items using a response format with scores ranging from 1 (totally disagree) to 5 (totally agree).

*Positive and negative affect.* We used the scales proposed by Keyes, Shmotkin and Ryff (2002) comprising six items each. On the positive affect scale participants indicated for how long, over the past 30 days, they had felt happy, cheerful, extremely happy, calm, satisfied and full of life. On the negative affect scale they indicated for how long, over the previous 30 days, they had felt sad, anxious, worried, hopeless, unhappy and useless. Response format was based on scores ranging from 1 (not at all) to 5 (all the time). Cronbach's for the positive affect scale was 0.80 and for the negative affect scale was 0.79.

*Anomie.* We used three items from the “General Social Survey” (GSS) (Davis & Smith, 1994). Participants responded, using a format of ordered categories with scores ranging from 1 (totally disagree) to 5 (totally agree), to the following statements: “many public employees do not care about the average citizen”, “the tendency of the average citizen is for things to get worse, not better”; “looking to the future, it's not right to bring children into the world the way things are”. These items have been used by several authors (e.g., Keyes, 1998) for measuring anomie, and show acceptable psychometric properties, with internal consistency ( $\alpha$ ) of 0.57 in the GSS study. In our study the scale showed similar reliability levels ( $\alpha = 0.55$ ).

*Neighbourhood safety.* Those participating in the study responded to the “Perceived Neighbourhood Safety”



scale (Keyes, 1998), comprising four items designed to measure safety and trust with regard to one's neighbours. Response format was based on ordered categories with scores ranging from 1 (totally disagree) to 5 (totally agree). The scale showed good internal consistency ( $\alpha = 0.71$ ).

**Contribution.** For the measurement of social contribution we used a version of the "Loyola Generativity Scale" (McAdams & St. Aubin, 1992), partially modified by Keyes (1998) and comprising five items. High scores on this scale indicate respondents who feel they have made contributions to society ("other people say I have made contributions to society"), who have shared their skills and experiences with others ("I try to share the knowledge I have acquired through my experience"), who like to teach, and who feel that other people need them. Participants responded by indicating whether the items on the scale described them "not at all", "only a little", "to some extent", or "well". Internal consistency ( $\alpha$ ) of the "Modified Loyola Generativity Scale" was 0.74.

**Perceived limitations.** We used the scale proposed by Lachman and Weaver (1998) that attempts to reflect the degree of control people have over their lives and the extent to which they perceive it as strewn with obstacles and unexpected turns of events. The scale includes statements such as: "there are many things that interfere with what I want to do". Participants indicated their degree of agreement or disagreement using a response scale with scores ranging from 1 (totally disagree) to 5 (totally agree). The scale showed good internal consistency ( $\alpha = 0.74$ ).

**Self-esteem.** We used Rosenberg's (1965) self-esteem scale. This instrument is made up of ten items, and has been used in numerous studies with a variety of populations (Breytspraak & George, 1982). Participants responded to each one of the items using a response format with scores ranging from 1 (totally disagree) to 4 (totally agree). The scale shows excellent psychometric properties, and in our study its internal consistency ( $\alpha$ ) was 0.86.

**Depression.** We used Zung's (1965) Self-Rating Depression Scale. This scale has been translated and validated for Spanish by Conde, Esteban and Useros (1976), and comprises 20 items including statements such as "I feel sad and depressed" or "I find it very hard to sleep". Participants responded to each one of the items using a response format with scores ranging from 1 (very little of the time/very rarely) to 4 (always/usually/all the time). The scale showed very good internal consistency ( $\alpha = 0.85$ ).

**Social action.** Participants responded, using a response format with scores ranging from 1 (never) to 4 (usually), to the following two questions: "have you worked with other people from your community to try and solve problems in society?" and "have you done any social work as a volunteer in an NGO or any other type of association?" Given the high correlation between the two responses ( $r = .78$ ,  $p < .01$ ) we created a single index.

**Recent social action.** Participants responded to the following question: "In the last twelve months, how many hours do you think you have devoted to volunteer social work?" Response format was open and number of hours was coded as a continuous variable.

**Perceived physical health.** Participants responded to the following statement: "You consider your state of physical health to be...". Participants responded using a response format with scores ranging from 1 (excellent) to 5 (poor).

**Number of visits to doctor.** Participants were asked to indicate the number of times they had seen a doctor (GP, specialist, emergency, hospital admission, etc.) over the previous year.

## RESULTS

Table 1 gives a broad overview of the linear correlations between the psychological construction of social order (social wellbeing, in Keyes' 1998 terms) and the scales with whose help we have explored some dimensions of health.

Aside from the specific data, the first finding to highlight is the general and significant relationship

**Table 1**  
Correlations of the Social Wellbeing dimensions with the different scales used

	Integration	Acceptance	Contribution	Actualization	Coherence
Anomie	-.113*	-.422**	-.183**	-.381**	-.259**
Neighbourhood safety	.198**	.209**	.088	.215**	.149**
Contribution	.334**	.193**	.443**	.264**	.185**
Limitations	-.247**	-.183**	-.211**	-.260**	-.329**
Self-esteem	.342**	.168**	.310**	.329**	.335**
Depression	-.275**	-.266**	-.278**	-.360**	-.325**
Social action	.169**	.187**	.323**	.112*	.142**
Recent social action	.115*	.032	.145**	0	.028
Perceived health	.103*	.024	.098*	.132**	.114*
Visits to doctor	.043	.047	.008	.089	.125**
Positive affect	.333**	.138**	.219**	.293**	.208**
Negative affect	-.243**	-.201**	-.182**	-.320**	-.267**
Wellbeing	.302**	.172**	.225**	.322**	.179**
Satisfaction	.340**	.088	.242**	.284**	.157**

\* $p < .05$

\*\* $p < .01$

which seems to exist between the five social wellbeing dimensions and the majority of the 14 scales to which the subjects in our sample responded. It is highly noteworthy how the different forms of perceiving, integrating in and experiencing social order are related to depression, to self-esteem, to the feeling of being socially useful and necessary (contribution), to anomie, to a certain feeling of helplessness and fatalism (limitations), to negative affect and positive affect, to a general feeling of wellbeing and to life satisfaction. Thus, the overall picture, despite coinciding with what was already known, is a highly significant one.

Within this general picture there are some findings that merit more detailed examination. The relationships emerging between self-esteem and depression and the five dimensions of social wellbeing are, on the whole, more solid and consistent, and highly significant in all cases ( $p < .01$ ). This was expected to be the case, since self-esteem has shown itself to be one of the variables most closely related to the different wellbeing measures, and depression is probably one of the most solid indicators of mental health.

As regards self-esteem, the data indicate that the integration, coherence and actualization dimensions are its most significant referents. Persons with a strong sense of belonging, with solid social bonds and links (social integration), with manifest interest and intention to give meaning to their life and the world in which they live (coherence), and who are confident about the future of society and about their capacity for producing wellbeing (actualization) are those that appear to have more positive feelings about and a more positive image of themselves. All of this constitutes a guarantee for wellbeing, and an open door to positive mental health. In this same sense and direction and with similar intensity there emerge two more of the scales, those of contribution and positive affect.

The first of these indicates, in a finding that seems to us particularly coherent, that people who feel useful and beneficial for the common good tend to also have strong feelings of belonging ( $r = .334, p < .01$  between the social contribution measure and the social integration dimension); there likewise seems to be a kind of mutual feedback in them (I receive support-I offer help), and they trust in social progress and in society as a source of wellbeing ( $r = .264, p < .01$  between contribution and the social actualization dimension).

With regard to people who feel surrounded by positive affect in their lives, they tend to coincide, as expected, with those who have strong feelings of belonging ( $r =$

$.333, p < .01$  between positive affect and the integration dimension), trust in the social dynamic ( $r = .293, p < .01$  between positive affect and the social actualization dimension) and feel that their life and their activity are of some use to the common good ( $r = .219, p < .01$  between positive affect and the social contribution dimension).

Despite the problems associated with single-item scales, that which we used for measuring wellbeing behaved better than expected, giving positive and highly significant relationships in all cases ( $p < .01$ ), especially with the social actualization dimension ( $r = .322, p < .01$ ), and this goes to underline, once more, the importance of people's perception and experience in the area of the macrosocial. Given the nature of this measure, what is truly important to highlight is how consistency and firmness in social wellbeing, defined in terms of positive perceptions and experiences, can be capable of minimizing the impact – always possible and difficult to control – of negative experiences in recent days. Something similar occurs for the results yielded by Diener's satisfaction scale: in all cases, except that of the social acceptance dimension, we find positive relationships, particularly intense for the dimensions of integration ( $r = .340, p < .01$ ) and social actualization ( $r = .284, p < .01$ ). Persons who show themselves to be satisfied with their life, who feel they have achieved their desired goals and who would repeat exactly the same steps appear to possess a solid feeling of belonging and firm social bonds (integration) and to trust in the progress that society can bring (social actualization).

On the other hand, and in an equally significant manner, Table 1 provides data on the "collision" between the psychological dimensions of social order and the depression scale. In all cases the results are significant, but once again we must stress that this is most intensely so with regard to those aspects involving beliefs and/or experiences with a macrosocial referent (social actualization and social coherence), so that people who have had difficulty finding meaning in life and in their world, or who have lost it early on due to some traumatic event, obtain higher scores on the depression scale ( $r = -.325, p < .01$  between the depression scale and the social coherence dimension). There are similar findings in the case of those who feel that everything happening around them occurs by pure chance, and that it is disorder and chaos that govern the social dynamic ( $r = -.360, p < .01$  between the depression scale and the social actualization dimension). Equally significant relationships can be observed

between the measure of depression employed and the absence of social bonds and links that guarantee a minimum level of social support (integration), a lack of trust in others (acceptance) and a lack of confidence in one's possibilities for contributing to the common good (social contribution). In any case, these are results that would be expected on the basis of the extensive body of previous findings from clinical research.

As also expected, in the same direction as depression (though with less intensity) we find anomie, limitations and negative affect, making up as coherent a block, even though in the opposite direction, as that of self-esteem, positive affect, contribution, satisfaction and wellbeing. People who see the future as full of gloom and think the trend is always for the worse are quite possibly the same ones that feel useless, hopeless and sad (negative affect), and that also think it impossible to attain order and control in their existence because they have the feeling that their life is ruled unavoidably by fate or some uncontrollable force (limitations). All of this leads to a marked lack of self-confidence ( $r = -.422, p < .01$  between anomie and the acceptance dimension), to a lack of meaning in their lives and the society in which they live ( $r = -.329, p < .01$  between limitations and the social coherence dimension) and to an uneasy mistrust and hopelessness with regard to the capacity for progress and development offered by society ( $r = -.320, p < .01$  between negative affect and the actualization dimension).

The data on social action are also worthy of close consideration. All the social wellbeing dimensions present significant correlations with involvement in the solution of social problems, leaving the (unsurprising) impression that people with both positive perception and experience of the world and of social order, and who therefore enjoy a good level of social wellbeing, become involved in social transformation and change. Even so, such behaviours focused on solving societal problems only appear to persist into the recent past in those persons who feel useful to the community and trust in its potential ( $r = .145, p < .01$  between recent social action and the contribution dimension) and who feel socially integrated.

Finally, all the social wellbeing scales, except that of acceptance, showed significant relationships with perceived physical health. However, if instead of considering perceived health we consider an objective indicator (number of visits to the doctor), the picture is somewhat bleaker, and this is only turned around if we take into account social coherence. This point is more

than merely anecdotal, since the sense we make of our life and the world around us and the meaning we give to them are good indicators of health. This becomes clear if we consider how trauma tends to demolish meaning and interfere with the metaphors of our existence.

## STUDY TWO

Considering the previous results, and to further explore the relationship between the self-reported health indicators proposed by Keyes and an objective indicator, number of visits to the doctor, we developed a second study in which, in addition to the social wellbeing measures employed in the first study, we included the remaining dimensions proposed by the Complete State Model of Health. Our hypothesis, in line with the findings of Study One, is that social coherence will be the indicator that shows the strongest and most significant relationship with number of visits to the doctor.

## METHOD

### *Participants and procedure*

Participants in the present study were 302 volunteers (168 men and 134 women) aged between 18 and 72 ( $M = 32, SD = 13$ ). Four percent of the sample reported an income (for the family unit) of under 12,000 euros a year, 19% reported an income of between 12,000 and 20,000 euros, 45% indicated a figure of 20,000 to 40,000 euros and 32% declared earnings of over 40,000 euros a year. As far as educational level was concerned, 53% had attended school up to age 18, 25% had diplomas or equivalent from higher education, and 19% had a degree or postgraduate qualifications. We used the same procedure as in the previous study.

### *Measures*

*Social wellbeing, Life satisfaction and Positive affect.* We used the same measures as in the previous study.

*Psychological wellbeing.* We used the version proposed by Díaz et al. (2006) of the Psychological Wellbeing Scales (Ryff, 1989). This instrument has a total of six scales (Autonomy, Self-Acceptance, Positive Relations, Environmental mastery, Purpose in life and Personal growth) and 33 items (4 to 6 items per scale), to which participants responded using a response format with scores ranging from 1 (very strongly disagree) to 6 (very strongly agree). All the scales showed good internal consistency, with values of between 0.83 and 0.70.

*Number of visits to doctor.* We used the same measure as in Study One.

## RESULTS

With a view to exploring the relationship between the thirteen mental health variables and number of visits to the doctor we carried out a path analysis using the AMOS 5.0 program (estimation method: maximum likelihood).

As can be seen in Figure 1, and in accordance with our hypothesis, the social coherence dimension (a wellbeing dimension that forms part of the diagnostic dimensions of mental health) was that which presented the clearest relationship with number of visits to the doctor ( $b = -.26$ ,  $p < .001$ ). Only three other indicators showed significant relationships with this variable: positive affect ( $b = -.23$ ,  $p < .01$ ), positive relations ( $b = -.19$ ,  $p < .05$ ) and personal growth ( $b = .17$ ,  $p < .05$ ). The thirteen dimensions explained, in total, 13% of the variance of the “visits to doctor” variable ( $SMC = .13$ ).

## DISCUSSION

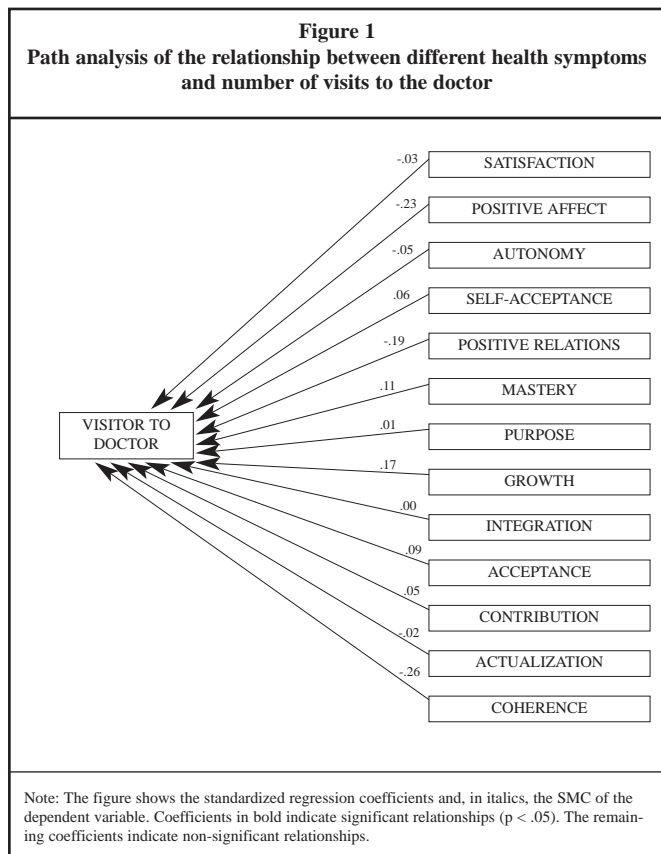
Social order not only offers data suitable for conversion into statistics, but is also in the minds of all of us. This

is the element – a far from objective one, indeed – that needs to be introduced from Psychology into Durkheim’s proposal, and this most neatly summarizes our intention throughout the present work. In an attempt to refine Durkheim’s holistic determinism we have taken advantage of the social wellbeing dimensions proposed by Keyes (1998), which have permitted us to talk about some of the components of social order not as they themselves are, but rather as people experience them and perceive them. They permit us to move, in Kantian fashion, from the fact itself to the perceived fact, a step which has indeed proved decisive for Psychology.

Thus, we can progress from the criteria of a linear model to a relational perspective that defines like no other the nature of the psychosocial approach. As Tajfel (1984) notes, it is a question of considering the extent to which certain aspects of human psychological functioning (satisfaction, self-esteem, depression, anomie and wellbeing are some of those we have dealt with) shape and are in turn shaped by small-scale and large-scale events that occur around us; the extent to which some aspects of our health can be affected by feelings of trust or mistrust, by the perception of sense of meaning and of control, or by the experience of support produced in us by our interpersonal world and the social reality in which we are immersed.

The data we have presented, apart from their quantitative value, can clearly be interpreted in terms of an association between certain psychological states (self-esteem, depression, satisfaction, wellbeing) and the experience and perception of some of the components of the social order of which we form part. This may appear something of a subjectivist and psychologistic tautology, but this is actually far from being the case, since while it is true that perception can ignore the data provided by reality (giving rise to an extreme psychologistic subjectivism) it is equally true that what we perceive and feel cannot be totally divorced from our interpersonal and social reality. The relational perspective we have adopted, which is in fact a socio-historical perspective, supports the second hypothesis: feelings of integration, of trust in others and in society, of self-efficacy and capacity for control, of social utility, and of meaning in our life reflect, in a sense that is both personal and socially shared, the objective characteristics of that social structure and order to which we have been referring since the initial paragraphs of this article.

Although it may not be the only one, without doubt one of the remedies available involves giving consistency and coherence to the social reality in which we are



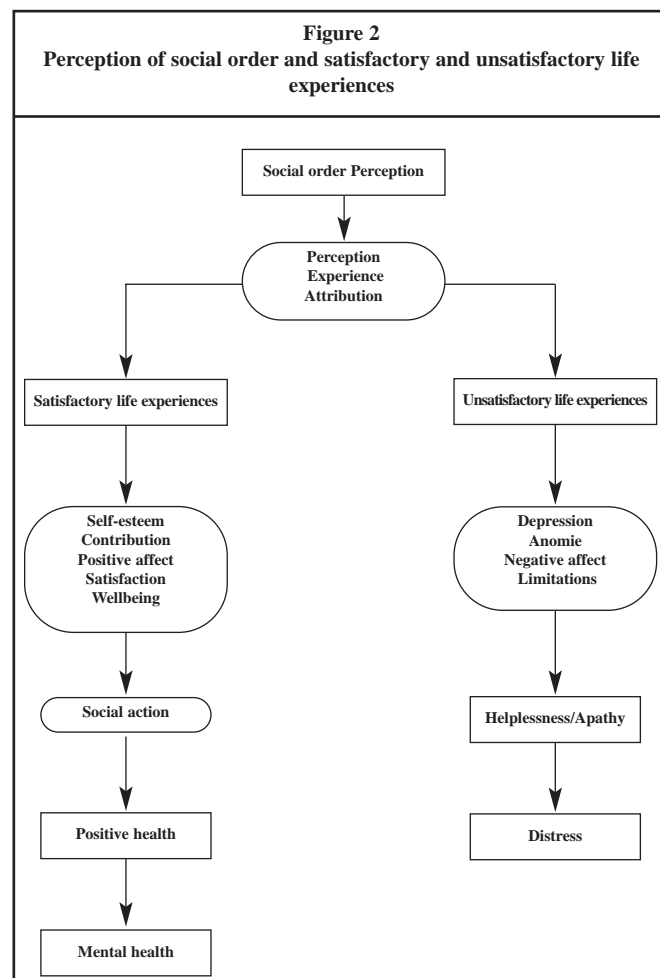


immersed, particularly that which is closest to us (the groups to which we belong). This idea indeed imbues Durkheim's theoretical proposal from "The Division of Labour in Society" (1893) to "Elementary forms of the Religious Life" (1912) – including, naturally, "Suicide" (1897) –, but can be interpreted today in a much more relevant way. From a positive health model, the social order acts not only as a balsam against the rough patches we come up against in life, but also as a guarantee of satisfactory levels of wellbeing and of the construction of positive conditions for health, to use the words of Seligman and Csikszentmihalyi (2000).

This is the idea we have tried to reflect in Figure 2, taking into account, of course, the data presented in Table 1. Based on the notion of social order as it is perceived throughout the dimensions that define social wellbeing, the data we have presented permit us to draw a clear distinction between the satisfactory life experiences (Fierro, 2004) that people have accumulated in their interpersonal and social life, and their unsatisfactory life experiences. Fierro's proposal seems particularly pertinent in this context: "It is obviously impossible to define mental health without some reference to personal wellbeing or to a happiness that includes some degree of quality in satisfactory life experiences" (Fierro, 2004, p. 7). In turn, it would not be possible to define psychological distress without reference to unsatisfactory life experiences. Such experiences depend on both personal wellbeing and social adjustment: Fierro postulates them as the clearest indicators of the bipolar mental health-mental illness concept. Our data support the crucial role of social adjustment, so that the experiences to which we have referred, while indeed pertaining to the individual's life, are primarily social experiences, or we might say "experiences of the social", both in "long-distance" contexts (social actualization or coherence) and in short-distance contexts (social integration or contribution), in one's interpersonal relations and in one's relationships with the social in its more abstract sense.

Positive perception and/or experience of the characteristics of social order (satisfactory social experiences) has a clearly beneficial effect on our psychological functioning, as reflected in our participants' responses to the scales measuring self-esteem, the experience of being socially useful, life satisfaction, global feelings of wellbeing and positive affect. This also appears to be the case, and in the same positive direction, for physical health, or for one of its most objective indicators, that of number of visits to the

doctor, as found in Study 2. It is in this sense, and with the necessary caution and prudence required in any interpretation of data, that we might return to Avia and Vázquez's (1998) notion of "intelligent optimism": visits to the doctor, an objective health indicator, appears to sit uneasily with positive relations with others defined by feelings of closeness, empathy and intimacy, and even more so with emotions of joy, cheerfulness, life satisfaction, serenity, and so on – in short, with positive emotions. When our experience takes on sombre tones, for reasons not dealt with in the present study (even though some are well known – traumatic events, to name one of the most obvious), there emerge symptoms of depression, lack of confidence about the future, hopelessness and feelings of being helpless and useless. The crucial data emerging from the present research, then, are undoubtedly those related to the importance for positive health of satisfactory social experiences: feeling the warmth, support and closeness of one's family and friends, trusting them, feeling the pleasure and satisfaction of contributing to the solution of their



problems, trusting in the future of the society in which one lives, seeing that one's life is not lived in vain, and being able to find meaning in this turbulent world.

Beyond the empirical data supporting such assertions, we are looking at a symptom, at one of the many indicators that unequivocally endorse the need to take into account psychologically mediated social order (subjects' perception and experience of it) in approaching the study of health. Among all such indicators, there is one, despite the problems involved in its measurement, which merits special comment, since its position in our analysis is also a special one. We are talking about social action, a key variable in positive health, and which puts us in mind of an old but vigorous Vygotskian conviction: the belief in people's capacity to modify their environment. Animals "adapt passively to the environment; the human being adapts the environment actively to itself" (Vygotsky, 1991, p. 46). Subjects as agents of their own behaviour (of their own health) and people's involvement in the solution of societal problems appear to be linked in some way to the feeling of belonging (to a satisfactory experience of social belonging), to feeling the warmth and support of those close to us, to the trust we place in others, and to the sense we make of the world in which we live.

In "The Division of Labour in Society", a key work of social theory, Durkheim continues to stress the importance of participation in social life, of people's connection with social processes, and of the presence of those "... bonds that link individuals to their family, to their home soil, to the traditions handed down to them, to the collective uses of the group" (Durkheim, 1982, p. 470). We are talking here once more about social integration and, at the same time, opening the way to a consideration of another element of social order as a benefactor of health: rituals as mechanisms of solidarity from which people extract "an impression of wellbeing". This is one of the hypotheses proposed by Durkheim in "Elementary forms of the Religious Life", and in relation to which recent work has been carried out on some aspects of the trauma resulting from the March 11th terrorist attacks on Madrid (see Jiménez, Páez & Javaloy, 2005). But that is indeed another story.

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