

Social-psychological Resources, Social Origin, and Social Support's Roles on Well-Being in College Freshmen

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Abstract: The current study examined three social variables associated with education (social origin, social support, and social-psychological resources) to see how they play a role in student well-being (physical well-being, psychological well-being, and health lifestyles). Students included 85 freshmen recruited from an urban university. The first year of college is a critical time for psychological and social growth. It represents the first time that many young adults are away from their parents and becoming independent. In addition, the college environment and the students' programs of study substantially impact student social, cognitive and personal development. Previous studies have shown that college-educated people are healthier and have more well-being. The current study found positive relationships between social variables associated with education and variables associated with health and well-being. Regression analysis found that social origin significantly explains some of the variance in health lifestyle. Additionally, social support significantly explains some of the variance in psychological well-being. The findings in this study illuminate the importance of social contexts as they apply to education's impact on health.

The positive association between education and health is well known. Education plays a role in establishing one's social position and is a means to achieve health. Traditionally, education refers to the process of learning over the span of one's entire life, both formally and informally. Education, income, and wealth are all indicators of what resources individuals hold and what sort of 'life chances' they have. The most frequently discussed causal pathways are those linking education to better material circumstances, healthier behaviors, higher social capital, and greater mental well-being (Lynch & Kaplan, 2000). Education works as a distributive function and it is linked closely to the social structure because it elevates individuals' social position and health achievement (Adler & Newman, 2002). The better-educated and more affluent members of society tend to live longer and healthier lives.

Ultimately, education provides knowledge and life skills that allow better-educated persons to have improved access to information and health promoting resources (Ross & Wu, 1995). In contrast, low investment by family and society in the education of children translate into poorer outcomes when those children grow up, including reduced employment, lower wages and income, and all the concomitant risks to health and well-being. The positive association between education and health has been established. However, how this association mediates an effect on well being is a multi-faceted and complex issue. The following sections present some research findings on understanding the relationship between education and health and how the present study will further explore the way in which this relationship operates.

Review of the Literature

Many reviews have assessed the consistent and robust evidence for a positive correlation between levels of education and health outcomes (Grossman & Kaestner 1997; Hartog & Oosterbeek 1998; Ross & Mirowsky 1999). Similarly, research on the outcomes of education suggests that learning can develop a number of psychosocial qualities including self-confidence (Dench & Regan, 1999; Carlton & Soulsby, 1999), self-efficacy (Wertheimer, 1997; Kubzansky et al, 1999), self-understanding (Cox & Pascall, 1994), competences, communication skills, civic engagement (Parry et al., 1992; Emler & Fraser, 1999), and a sense of belonging to a social group (Qarvis & Walker, 1997; Emler & Fraser, 1999). These psychosocial outcomes of education may promote attitudes, cognitive abilities, and life circumstances that are conducive to positive health outcomes (Hammond, 2004).

Additionally, research has indicated that college has a uniquely substantial impact on students' knowledge, cognitive, and personal development (Gamson, 1991). The relationship between a college education and numerous quality-of-life indicators has been well established. For example, research studies have found that college-educated people, compared to those with less education, are healthier and live longer (Gamson, 1991).

It is less well understood, however, the ways in which education is a proxy for better health. Given the positive correlation between education and health, it is critical to understand how this relationship works. Research shows that a wide range of variables contribute to the link between education and health including sociodemographic (economic, social, environmental, and medical), behavioral, and psychological (personal control and social support) factors (Ross and Wu, 1995). For example, education may increase social resources (psychological and economic), which then shape problem-solving abilities and lifestyle behaviors. Social resources may also impact one's health through an individual's sense of control - the belief that one can and does master, control, and shape his/her own life and health lifestyles.

Ross and Wu (1995) examined social-psychological resources and health lifestyle among respondents with less than a high school diploma, a high school diploma to some college, and a college degree or more. They found that high educational attainment improves health both directly and indirectly. Social-psychological resources and health lifestyle explain some of the association between education and health, but overall, education remains the significant predictor of good health.

Additional research by Reynolds and Ross (1998) on the socio-economic factors associated with the link between education and health found that education was positively associated with better health for people of both high and low socio-economic status (SES). SES appears in the literature as including education, income, and occupation. Of these three variables, education is the strongest because it affects both an individual's potential income and occupation (Adler & Newman, 2002). The study by Reynolds and Ross (1998) examined the links between social origins (educational attainment and household income), achieved status, and adult well-being. Using data from a national survey of individuals age 18 and older, they found that years of educational attainment had positive, significant effects on physical and psychological health. The more years of schooling, the higher the individual's well-being. The effects of each year of education were linear in most analyses. Within each year of education, however, there were variations in well-being. When looking at the percent of the effect of respondents' education on well-being, the range was from 81 percent to 91 percent. (In all cases, education's effect on well-

being was significant at $p < .001$). This suggests the need for more research on the benefits to well-being from education while holding education level constant.

In summary, research has shown a clear link between education and health. Research has also shown that the factors accounting for the link include social variables (social origin, social-psychological resources, social support), psychological well-being, and health lifestyle. Although these links are clear and documented, there has been little research conducted to delineate the pathways by which these variables are associated within one educational level. The current study examined social variables associated with increased health and well being in an attempt to identify these pathways and extend previous research. This study focused on variables contributing to the association between education and health across individuals with the same educational attainment. This study utilized measurement items employed in national studies of adults 18 years and older (Reynolds & Ross, 1998 and Ross & Wu, 1995) to examine the factors associated with well-being among undergraduate freshmen students. Specifically, this research examined social variables associated with education (social-psychological resources, social origin, and social support) to see their effect on variables associated with increased well-being (health lifestyles, physical well-being, and psychological well-being).

Method

Participants

Participants were 128 undergraduate freshmen enrolled at a large, public, urban university. Of the 128 students who were administered the questionnaire, 85 completed and returned the self-administered questionnaire (52 female and 33 male students). The respondents reflected the ethnic composition and age range of the freshmen undergraduates on that campus. The sample was 48.2% Caucasian, 38.8% African American, 7.1% Asian, 3.5% Latino, and 2.4% other ethnic groups. The participants were between 16 and 21 years of age. Eighty percent were 18 or 19 years of age, with a mean age of 18.45.

Procedure

The methods were in accordance with the guidelines set forth by the university's Institutional Review Board. A paper questionnaire was administered during the final 30 minutes of freshmen sociology and freshmen new student orientation classes during the fall semester. The participants were instructed to complete the informed consent form and the questionnaire, which together took approximately 10-20 minutes. Once finished, respondents received informational pamphlets about the on-campus counseling center.

Questionnaire Instrument

The study questionnaire was a compilation of items from two national surveys: *National Survey of Families, and Households* (NSFH) (Reynolds & Ross, 1998) and the *Work, Family, and Well-Being* (WFW) survey (Ross & Wu, 1995). The questionnaire compiled for the current study did not alter the previous instruments, but instead combined the instruments to extend previous research and examine in what ways social variables associated with educational attainment effect variables associated with increased well-being. On one particular subset (Reynolds & Ross, 1998), the psychological well-being questions correlate .92 with the full *Center of Epidemiological Studies'* scale of depression (CES-D) and have been used in

numerous studies of psychological well-being. The sections assessing health lifestyle, social background, social-psychological resources, and social support were all taken from the Ross and Wu (1995) questionnaire and have a reported internal consistency reliability measured by Cronbach's alpha of .80 to .85.

The compiled questionnaire used for the present study consisted of three sections. The first demographic section inquired about student's background. There were four questions in this section including age, ethnicity, gender, and college classification. The second section inquired about the dependent variables, student well-being and health lifestyle. It consisted of 17 questions on student daily activities and emotional temperament. Health lifestyle items included a two item exercise index measuring the number of days per week respondents walk and engage in strenuous exercise. A third question used a 5-point Likert scale self assessment of the student's physical well being, with answer choices from "very poor" to "very good". Seven additional questions assessed health lifestyle using an index of physical functioning. Respondents were asked their difficulty performing everyday tasks, with answer choices being "a great deal of difficulty", "some difficulty", and "no difficulty". The remaining questions in this section included a seven-item version of the *Center of Epidemiological Studies'* scale of Depression (CES-D) to determine psychological well-being.

The third and final section assessed the independent variables and included 12 questions about respondents' social origin, social-psychological resources, and social support. Social background, or the respondents' social origin, was assessed by knowledge of respondents' parents' educational attainment and household income. Social-psychological resource questions asked respondents if they believed they could claim control over good outcomes in their lives. For example, "I am responsible for my own success". Finally, social support questions measured the amount of emotional support the respondents believed they had. (see Appendix for complete list of questionnaire questions)

Results

Descriptive analysis, correlation, and multiple regression were used to examine the relationships among the independent variables: social-psychological resources, social origin, and social support, and the dependent variables: health lifestyle, physical well-being, and psychological well-being. Regarding health lifestyles (Table 1), more than half (56.5%) of the participants stated they walk "every day" and 37.6% engage in strenuous exercise "about once a week" or "twice a week". In addition, the majority (82.4%) of the participants rated their own health as "satisfactory" or "good".

Table 1
Health Lifestyle Descriptives

Questionnaire Item	Frequency	(%)
N = 85		
How often do you take a walk?		
Never	4	(4.7)
Once a month or less	8	(9.4)
About twice a month	4	(4.7)
About once a week	8	(9.4)
Twice a week	2	(2.4)
Three times a week	6	(7.1)
More than three times a week	5	(5.9)
Every day	48	(56.5)
How often do you do strenuous exercise such as running, basketball, aerobics, tennis, swimming, biking?		
Never	6	(7.1)
Once a month or less	12	(14.1)
About twice a month	16	(18.8)
About once a week	15	(17.6)
Twice a week	17	(20.0)
Three times a week	7	(8.2)
More than three times a week	7	(8.2)
Every day	5	(5.9)
What is your assessment of your general health?		
Poor	4	(4.7)
Satisfactory	34	(40.0)
Good	36	(42.4)
Very Good	11	(12.9)

Table 2 shows the means for the well being questions. Although the freshmen reported high well being, respondents had the most psychological difficulty “keeping their mind on what they were doing”.

Table 2
Psychological Well-Being Descriptives

Questionnaire Item	<u>M</u>	<u>SD</u>
N = 85		
How many days*during the past week have you:		
Felt you just couldn't get going?	1.88	1.41
Felt sad?	2.34	1.78
Had trouble getting to or staying asleep?	2.40	1.77
Felt that everything was an effort?	2.51	1.94
Felt lonely?	2.48	2.15
Felt you couldn't shake the blues?	2.11	1.84
Had trouble keeping your mind on what you were doing?	3.27	2.24

* Between 1 and 7 days

Descriptive analysis of the social variables (Table 3) found that eighty eight percent of respondents claimed to know their mother's education and 76.5% claimed to know their father's education. In addition, the participants demonstrated having social-psychological resources. Eighty-six percent of respondents agreed that they were “responsible for their own success” and 88 percent reported that they “can do just about anything they set their mind to”. A large number of the participants, 84 and 85 percent respectively, had “someone to turn to for support” and “someone they can really talk to”.

Table 3
Social Background and Social Support Descriptives

Questionnaire Item	<u>Frequency</u>	<u>(%)</u>
N = 85		
Knowledge of Mother's Education	75	(88.2)
Knowledge of Father's Education	65	(76.5)
I am responsible for my own success		
Strongly Disagree	1	(1.2)
Disagree	4	(4.7)
Neutral	7	(8.2)

Agree	30	(35.3)
Strongly Agree	43	(50.6)

I can do just about anything I really set my mind to

Strongly Disagree	0	
Disagree	0	
Neutral	10	(11.8)
Agree	34	(40.0)
Strongly Agree	41	(48.2)

My misfortunes are the result of mistakes I have made

Strongly Disagree	1	(1.2)
Disagree	6	(7.1)
Neutral	25	(29.4)
Agree	40	(47.1)
Strongly Agree	13	(15.3)

I am responsible for my failures

Strongly Disagree	1	(1.2)
Disagree	0	
Neutral	14	(16.5)
Agree	50	(58.8)
Strongly Agree	20	(23.5)

The really good things that happen to me are mostly luck

Strongly Disagree	13	(15.3)
Disagree	36	(42.4)
Neutral	25	(29.4)
Agree	10	(11.8)
Strongly Agree	1	(1.2)

There's no sense in planning it – if something good is going to happen it will

Strongly Disagree	11	(12.9)
Disagree	28	(32.9)
Neutral	28	(32.9)
Agree	13	(15.3)
Strongly Agree	5	(5.9)

Most of the problems are due to bad breaks

Strongly Disagree	2	(2.4)
Disagree	37	(43.5)
Neutral	30	(35.3)
Agree	15	(17.6)

Strongly Agree	1 (1.2)
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I have little control over the bad things that happen to me

Strongly Disagree	3 (3.5)
Disagree	41 (48.2)
Neutral	27 (31.8)
Agree	12 (14.1)
Strongly Agree	2 (2.4)

How much do you agree with the statement:

I have someone I can turn to for support and understanding when things get rough.

Strongly Disagree	1 (1.2)
Disagree	4 (4.7)
Neutral	9 (10.6)
Agree	26 (30.6)
Strongly Agree	45 (52.9)

How much do you agree with the statement:

I have someone I can really talk to.

Strongly Disagree	1 (1.2)
Disagree	3 (3.5)
Neutral	9 (10.6)
Agree	23 (27.1)
Strongly Agree	49 (57.6)

Analysis of the relationships between the independent variables and the dependent variables found four moderate correlations with significant results (Table 4). Physical well-being had a positive correlation (.287) with health lifestyle. Health lifestyle was also positively correlated (.321) with social origin. Students' social-psychological support and social resources were positively correlated (.335). Additionally, there was a negative correlation (-.419) between student psychological well-being and social support, signifying that the more social support the student had, the fewer days of depression experienced.

Table 4

Intercorrelations between Dependent Variables (physical well-being, health lifestyles, and psychological well-being) and Independent Variables (social support, social-psychological resources, and social origin)

Subscale	1	2	3	4	5	6
N = 85						
1. Phy. Well-being	--	.287**	-.175	.209	.151	.184
2. Health lifestyle		--	-.118	.090	.083	.321**
3. Psy. Well-being			--	-.419**	-.174	.077
4. Social support				--	.335**	.127
5. Social resources					--	.164
6. Social origin						--

** Significant at the 0.01 level (2-tailed).

Regression analysis was performed to see which independent social variables predicted which aspects of the dependent well-being variables. For the independent variables, the eight items for social psychological resources were summed, the two items for social origin were summed, and the two items for social support were summed. Similarly, for the dependent variables, the nine items for health lifestyles were combined and the seven items for psychological well-being were summed (physical well-being consisted of only one item). The appendix describes how each index within the variable groupings was coded. The regression analyses revealed two significant findings (Table 5). Social origin significantly explained 10 percent of the variance in health lifestyle ($R^2 = .103$, $p < .003$). The freshmen participants who knew their parents' educational attainment had significantly better health than those who were unaware of their parent's educational attainment. Additionally, social support significantly explained 18 percent of the variance in psychological well-being ($R^2 = .176$, $p < .000$). The more social support freshmen had, the fewer days they felt sad or depressed.

Table 5

Summary of Regression Analysis for Social Variables Associated with Increased Well-Being

Variable	B	SE B	β	R^2
Health Lifestyles &				
- Social-psychological Resources	--	--	--	
- Social Origin	.76	.25	.32 *	.10
- Social Support	--	--	--	

Physical Well-being &				
-	Social-psychological Resources	--	--	--
-	Social Origin	--	--	--
-	Social Support	.05	.02	.21 .04
Psychological Well-being &				
-	Social-psychological Resources	-.60	.23	-.27 .07
-	Social Origin	--	--	--
-	Social Support	-.67	.16	-.42 * .18
Social Variables & Well-Being Variables		.06	.14	.05 .00

Note. Dashes indicate the beta coefficients could not be generated.

* $p \leq .05$.

Discussion

This study examined three social variables associated with education to see how they play a role in freshmen student's well-being. Research has shown a clear link between education and health. This study focused on social variables' contributions to the association between education and health across individuals with the same educational attainment.

The first year of college is a critical time for psychological and social growth. It represents the first time that many young adults are away from their parents and becoming independent. In addition, the college environment and the students' programs of study substantially impact student social, cognitive and personal development. Previous studies have shown that college-educated people are healthier and have more well-being. The current study found psychosocial variables associated with education that are central to the processes that link the effects of education with health outcomes (Hammond, 2004). The results replicate some of the previous findings by Reynolds and Ross (1998) that these associations appear to support education's effects on well-being.

In the current study, freshmen who know their parents' educational attainment live a significantly better health lifestyle than those who are unaware of their parent's educational attainment. Additionally, freshmen that have supportive individuals around them report significantly better psychological well-being. When individuals have solid support systems it contributes a positive impact upon their psychological health. This can contribute to positive family functioning and social cohesion which together additionally support their psychological health (Hammond, 2004). However, given that more than half of the respondents reported both

positive well-being and positive socio-psychological factors, it is not clear if these findings are spurious or illustrate a clear positive relationship between social origin and health.

Taken together, research on the associations between education and health shows that there are connections and intercorrelations that vary depending on the health outcome and social context. There may also be other variables that play a role in the association. For example, additional studies may find that gender, age, and/or ethnic background of the learner may also have important significance (Hammond, 2002). Additional variables that may play a role include the number of times the individual regularly visits the doctor, the type of diet they have, and/or other overall healthy living variables.

The findings in this study illuminate the importance of social contexts as they apply to education's impact on health. Studies that examine the social benefits of education find that education has a positive effect on social well-being by encouraging individuals to contribute as a member of society (Desjardins, 2003). This is accomplished through increasing a person's sense of control, the belief that one's life and health result from one's own actions and decisions (Ross & Wu, 1995). Education may also directly affect health because it develops habits, skills, resources, and abilities that enable people to shape their lifestyle in a manner that improves well-being (Hammond, 2002).

Education has the potential to enhance all health outcomes by enabling individuals to perceive their lives in a broader context. Understanding life within a broader context provides individuals with new interests, provides new opportunities, and can then generate a new sense of purpose, hope, self-esteem, self-efficacy, and personal growth (Hammond, 2004).

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Appendix

Section I:

Demographics

Section II:

Health Lifestyle *adapted from Ross and Wu (1995)

An index of walking and strenuous exercise measured as the number of days walked per week. Respondents were asked, "How often do you take a walk? Would you say never (= 0), one a month or less (= .25), about twice a month (= .5), about once a week (= 1), twice a week (= 2), three times a week (= 3), more than three times a week (= 5), or every day (= 7)?" Strenuous exercise is measured by asking respondents, "How often do you do strenuous exercise such as running, basketball, aerobics, tennis, swimming, biking?" (coded the same way)

Physical Well-Being * adapted from Reynolds and Ross (1998)

Respondent's assessment of general health – ranging from very poor (1), poor (2), satisfactory (3), good (4), or very good (5).

Physical Functioning

Comprised of an index of seven items: "How much difficulty do you have (1) going up and down stairs; (2) kneeling or stooping; (3) lifting or carrying objects less than 10 pounds, like a bag of groceries; (4) using your hands or fingers to grasp or handle small objects; (5) seeing, even with glasses; (6) hearing; (7) walking?" (coded 0 = a great deal of difficulty, 1 = some difficulty, and 2 = no difficulty). The low end of the scale reflects high physical impairment or disability; the high end reflects high physical functioning.

Psychological Well-Being *adapted from Reynolds and Ross (1998)

The questionnaire incorporated a modified, seven-item version of the Center of Epidemiological Studies' scale of Depression (CES-Dm). Respondents were asked "how many days during the past week (0-7) have you: felt you just couldn't get going? Felt sad? Had trouble getting to sleep or staying asleep? Felt that everything was an effort? Felt lonely? Felt you couldn't shake the blues? Had trouble keeping your mind on what you were doing? The level of depression is equal to the average of all seven responses, with a range from 0 to seven. 0 equals the lowest mental health and 7 equals the best.

Section III:

Social Origin * adapted from Reynolds and Ross (1998)

Assessment of respondent's parents' educational attainment. Scores are equal to the average years of education attained by the respondent's parents. In addition, knowledge of parent's educational attainment will be scored. Parents' education unknown will be coded as 0, if the respondent knows both parent's years of education it will receive a score of .5, if they know neither parents' educational attainment, as core of 1.0.

Assessment of economic status will be measured by asking household income in thousands of dollars per year.

Social-Psychological Resources *adapted from Ross and Wu (1995)

Claiming Control over good outcomes:

- (1) "I am responsible for my own success."
- (2) "I can do just about anything I really set my mind to."

Claiming Control over bad outcomes:

- (3) "My misfortunes are the result of mistakes I have made."
- (4) "I am responsible for my failures."

Denying control over good outcomes:

- (5) "The really good things that happen to me are mostly luck."
- (6) "There's no sense in planning it – if something good is going to happen it will."

Denying control over bad outcomes:

- (7) "Most of the problems are due to bad breaks."
- (8) "I have little control over the bad things that happen to me."

Responses to control questions (1 thorough 4) are coded -2 = strongly disagree, -1 = disagree, 0 = neutral, 1 = agree, 2 = strongly agree. Responses to lack of control questions (5-8) are coded 2 = strongly disagree, 1 = disagree, 0 = neutral, -1 = agree, -2 = strongly agree. A means score sense-of-control index will be created coded from low sense of control (-2) to high sense of control (2).

Social Support *adapted from Ross and Wu (1995)

Measured by responses to two questions about emotional support: "How much do you agree with the statement: 'I have someone I can turn to for support and understanding when things get rough,' and 'I have someone I can really talk to?'" Coded -2=strongly disagree, -1=disagree, 0=neutral, 1=agree, 2=strongly agree.

* *Questionnaire measurement items adopted from:*

Reynolds and Ross (1998) – Items used in the study include Physical Well-Being, Psychological Well-Being, and Social Origin. Additional measurement items used in the Reynolds and Ross study included Education (years of formal education completed), Work characteristics (full- or part-time), and Economic Status (household income).

Ross and Wu (1995) – Items used in the study include Social Origin, Social-Psychological Resources, Social Support, and Health Lifestyle. Measurement items from the Ross and Wu study were adapted from The Work, Family, and Well-Being telephone sample (Ross, 1990), and also included Education (years of formal education), Work and Economic Conditions (four items), and Work Fulfillment (3 items).