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## Social Integration and Psychological Wellbeing in a Sample of the Swedish-speaking Minority of Western Finland

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**Abstract.** The role of social integration in determining subjective psychological wellbeing in a sample of Swedish-speaking Finns in Ostrobothnia was investigated. A questionnaire was completed by 298 respondents (208 females, 90 males). The mean age was 32.7 years (*SD* 13.4) for females and 28.9 years (*SD* 13.4) for males. The age span was between 16 and 90 years. The questionnaire consisted of four scales measuring social integration. Females scored significantly higher on access to social benefits, positive social relations, and trust in the Finnish judiciary system. No sex difference was found for satisfaction with the neighbourhood. The mean values were overall high for both females and males. Respondents over 30 years of age reported significantly more positive social relations and more satisfaction with the neighbourhood compared to respondents under the age of 30. Respondents belonging to a group with high scores of social integration scored significantly lower on anxiety, depression, and somatisation. Conclusively, social integration can be regarded as a resource for psychological health.

**Keywords.** social integration, psychological wellbeing, sex differences, Finland, Swedish-speakers

### 1. Introduction

Social integration, within the context of studies on immigration and minorities, may be described as a process of becoming part of and belonging to a specific group. The level of social integration may be assessed through indicators such as rights and citizenship, language and cultural knowledge, safety and stability, social bridges, bonds and links, employment, housing, education, and health (Ager & Strang, 2008). In addition, integration may be regarded as a dynamic and structured development during which all the members of a society participate in the creation of dialogue, in order to maintain positive human social relationships. It brings together different ethnic groups without losing their identities, and it gives access to all areas of community life (Berry, 2011; Ratts & Pedersen, 2014).

Social integration has been treated as a characteristic of individuals rather than of communities. It refers to the extent to which an individual participates in the social community, in social activities, and perceives herself or himself as an integrated member of the community in question (Brissette, Cohen, & Seeman, 2000). The level of integration depends on the quality and frequency of informal social relationships (e.g. having a spouse or other relatives from the community) or formal (e.g. engagement with religious institutions and voluntary organizations) (Umberson & Montez, 2010). It is vital for both the individual's health and wellbeing and the

health and vitality of the entire community that an individual is well connected with others and included in the community (Berkman & Glass, 2000).

A broad range of interdisciplinary studies have shown that the quality and quantity of social relationships, in the form of integration and participation, are positively related to health and wellbeing. It is widely recognized that social relationships and affiliations have powerful effects on physical and mental health (Berkman, Glass, Brissette, & Seeman, 2000). Thus, healthy people are more likely to be engaged in multiple roles and various social networks literally, because they are healthier (Wethington, Moen, Glasgow, & Pillemer, 2000).

There is strong evidence for the fact that social integration and the quality of existing social ties lead to reduced mortality risks (Berkman, 1995; House, Landis, & Umberson 1988), a better state of mental health (Seeman, 1996), and fewer depressive symptoms (Cohen & Wills, 1985; Pössel, Burton, Cauley, Sawyer, Spence, & Sheffield, 2018). Studies of patient populations show that social integration is associated with a greater likelihood of survival following a heart attack (Berkman, 1995), and lesser likelihood of suffering a recurrence of cancer (Helgeson, Cohen, & Fritz, 1998). Lack of participation in the social community is associated with increased mood disorders (Naicker, Galambos, Zeng, Senthilselvan, & Colman, 2013; Whisman, 2017), anxiety disorders (Priest, 2013), chronic health conditions (De Vogli, Chandola, & Marmot, 2007), and poor self-rated physical health (Liu & Umberson, 2008; Thoits, 1995). The quality of formal and informal relationships within the social community is one of the most significant indicators of healthier, happier, and even longer life. This rivals in magnitude the effect sizes of well-established risk and protective factors such as cigarette smoking, alcohol consumption, obesity, hypertension, clean air, flu vaccine, cardiac rehab, and exercise (Delhey & Dragolov, 2016; Holt-Lunstad, Smith, & Layton, 2010; Holt-Lunstad, Birmingham, & Light, 2015; Pinker, 2015).

### *1.1. Formal and Informal Relationships and their Effects on Wellbeing*

The works of Boissevain (1974), Berkman (1995), and Lin, Ye, and Ensel (1999) demonstrate that human relations consist of multiple layers that extend from the egocentric perspective to formal and informal social life; from the most intimate partner relations to social networks such as connections to close relatives and friends, and to weak social ties such as involvement in community and voluntary organizations. The latter does not involve close individual interactions; however, it provides a sense of belongingness and general social identity that promotes mental health (Durkheim, 1897; Faris & Dunham, 1939). The current study focuses on the benefits and costs of social relationships that are distributed within the population, based on gender (cf. Kawachi & Berkman, 2001) and stage in life (Schnittker, 2007).

There are persistent gender differences in the degree and patterns of integration into society which vary greatly across countries and regions, e.g. Western Europe versus southeastern Europe (Pascall & Kwak, 2005; Pollert, 2005). Thus, variation in social structures could lead to better or worse health outcomes. Social cohesiveness can protect against depressive illnesses, and a repressive nature of social regulation may cause an excess of anxiety disorders (Durkheim, 1897). In a classic study by Brown and Harris (1978), adherence to traditional forms of social engagement appeared to have simultaneously protective and damaging effects on women in two rural areas. Women's participation in traditional life patterns, such as regular church going and craftwork, predicted lower rates of depression, and, at the same time, it also predicted a higher rate of anxiety disorders (Brown & Harris, 1978). A study by Dressler and Badger (1985) found that supportive relationships with the extended family had mental benefits for men, but not for women. Corin (1985) reported that for women, more support is associated with more mental health symptoms due to the costs associated with conformity within a

traditional community and/or within a small minority group in a culture of a majority. The prevalence and risk for depressive disorders are, in the Western cultural sphere, higher in women than in men, beginning at mid-puberty and persisting through adult life (Piccinelli & Wilkinson, 2000).

Fothergill, Ensminger, Robertson, Green, Thorpe, and Juon (2011) conducted a longitudinal study among urban African American women that assessed effects of community engagement on physical functioning, self-rated health, anxious mood, and depressed mood, over a 22-year period. They found that women with diverse and persistent (engagement that continues over a prolonged period) community engagement had significantly better health than non-involved women. Persistently engaged women were less likely to report anxious or depressed mood than those with only early community engagement. Women with both persistent and diverse community engagement showed better physical functioning than those with a persistent community engagement only (Fothergill et al., 2011).

A strong sense of coherence within the community, and a good subjective state of health, were associated with each other in a Finnish sample consisting of both women and men. The association was still present when adjusted for age and level of socio-economic status, social integration, and realized opportunities for activities during leisure time. A strong sense of coherence could be interpreted as representing an autonomous personal resource capable of contributing directly to subjective health (Suominen, Blomberg, Helenius, & Koskenvuo, 1999).

In the examination of social integration in relation to age, studies have documented links between social networks and late-life wellbeing. In a study by Fuller and Fiori (2017), frequency of community interaction, which is a typical component of social integration, was associated with a decline in depressive symptoms, an increase in life satisfaction, and an increase in self-rated health over time, among the elderly. Also, lower satisfaction with social ties predicted increased depressive symptoms over time (Fuller & Fiori, 2017). Furthermore, associations between late-life social integration and health have been found to be reciprocal. A community-based study investigated whether depressive symptoms, chronic health conditions, functional limitations, and self-rated health independently predicted multiple dimensions of social integration. The results showed that self-rated health was the most consistent predictor of social integration over time. The subjective perception of health appeared to have greater implications for social integration over time than more objective health, including symptoms and conditions (Toyama, Toyama, & Fuller, 2019).

Generally, findings from community-based studies show that the social interactions that elderly people have within their networks become more satisfying with age, despite the decrease in social network size (Lansford, Sherman, & Antonucci, 1998). Typically, older adults account for greater satisfaction and more positive social experiences than younger adults do (Birditt & Fingerman, 2003; Charles & Piazza, 2007). The perception of social interaction and social support within one's own environment grows more positive with age (Field & Minkler, 1988). A literature review indicated that older adults engage in strategies that optimize positive social experiences and minimize negative ones, and older adults apply principles of reciprocity and forgiveness in their communication with others more than younger ones (Luong, Charles, & Fingerman, 2011).

### *1.2. Social Integration and Health within the Study Population*

Finland is an egalitarian and democratic welfare state adhering to the principles of the so-called Nordic Welfare Model, which ensures long-term social and economic stability to its citizens (Kuisma, 2017). This model pays attention to social integration, social cohesion and inclusion,

in addition to a high standard of living, small income disparities, promotion of social mobility, sound public finances, and an emphasis on the environment (Vihriälä & Valkonen, 2014).

In the Human Development Report (2019), Finland's HDI value for 2018 was 0.925, which placed the country in the very high human development category, as #12 out of 189 countries. Practically, this means that inequality is low which promotes a healthy society, strengthens social cohesion and people's trust in government, institutions, and each other (Human Development Report, 2019). The 2019 Global Peace Index ranked Finland as #14 on global peacefulness (Institute for Economics & Peace, 2019). The World Happiness Report 2020, for the third time in a row, ranked Finland as the happiest country in the world, based on how happy citizens perceive themselves to be (World Happiness Report, 2020).

The population of the current study resides in the bilingual Ostrobothnia region in Western Finland. It has a Swedish-speaking minority that makes up approximately half of the population within the region, while the Swedish-speakers reach only 5,9% of the total population of the country (Statistics Finland, 2020). Within the region, many inhabitants choose to follow Swedish rather than Finnish media, Swedish current affairs, and cultural events. They value personal equality and an enhancement of individual autonomy in addition to honesty, modesty and open-mindedness (McRae, Helander, & Luoma, 1999; Mead, 1993). The Swedish-speaking community in Western Finland holds a high amount of social capital that is associated with their wellbeing and health. Such social capital patterns as voluntary associational activity, friendship networks and religious involvement are significantly associated with good self-rated health (Hyypä & Mäki, 2003).

The current study explores a conceptual understanding of the dynamics of social integration among the Swedish-speaking minority of Western Finland and its relationship with the populations' psychological wellbeing in terms of sex and age differences.

## 2. Method

### 2.1. Sample

A questionnaire was completed by 298 Swedish-speaking respondents in Western Finland, comprising of 208 females and 90 males. The mean age was 32.7 years for the females (*SD* 13.4), and 28.9 years (*SD* 13.4) for the males. The age span was between 16 and 90 years. The age differences was significant [ $t_{(296)} = 2.25, p = .025$ ]. Three age groups were constructed: I: 16–20 years (35 females, 28 males), II: 21–30 years (80 females, 33 males), III: 31–90 years (93 females, 29 males).

### 2.2. Instrument

The questionnaire consisted of four scales measuring social integration: access to social benefits, satisfaction with the neighbourhood, positive social relations, and trust in the Finnish judiciary system. The items were on a five-point scale (0 = disagree completely, 1 = partly disagree, 2 = neutral, 3 = partly agree, 4 = agree completely). See Table 1 for individual items and Cronbach's alphas of the scales.

Table 1  
*Single Items of Four Scales Measuring Aspects of Social Integration (N = 298)*

*Access to Social Benefits* (8 items,  $\alpha = .83$ )

People working in the local institutions, e.g. shops or banks, are helpful in assisting me.

I can easily access public services such as hospitals, police, etc.

I can easily access health care.

- 
- I can easily receive an education.
  - I am certain about my work possibilities in the future.
  - I have career opportunities in Finland.
  - I have enough money for household necessities.
  - I have equal rights with everyone else in this country.

*Satisfaction with the Neighborhood* (8 items,  $\alpha = .82$ )

- I talk with my neighbors often.
- I know my neighbors well.
- Neighbors are hospitable and friendly.
- I take part in social activities in my village/city.
- I feel safe walking in the nights where I live.
- I wish to live in my current city/village permanently.
- I wish to live in Finland permanently.
- Finland is my real home.

*Positive Social Relations* (4 items,  $\alpha = .72$ )

- People from different groups perceive me in a positive way.
- It is easy for me to communicate with people from different ethnic groups in different social settings.
- My rights, beliefs, and opinions are respected by others.
- I am treated with respect by others in the society.

*Trust in the Finnish Judiciary System* (7 items,  $\alpha = .80$ )

- I respect and obey Finnish laws.
  - I have trust in the government of Finland.
  - I have trust in the Finnish legal system.
  - I pay income and other taxes honestly and on time.
  - I get the same benefits as everyone else in this country.
  - I have freedom to pursue my life as I choose in Finland.
  - I get all the support I need from the society.
- 

The questionnaire also included three subscales from the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). The single items of the scale measuring anxiety were nervousness or shakiness inside, suddenly scared for no reason, feeling fearful, trouble concentrating, spells of terror or panic, feeling so restless one could not sit still (6 items,  $\alpha = .88$ ). Depression was measured with the following items: feeling lonely, feeling blue, feeling no interest in things, feeling hopeless about the future, feeling of worthlessness, thoughts of ending your life (6 items,  $\alpha = .88$ ), and somatisation with: faintness or dizziness, pains in heart or chest, nausea or upset stomach trouble getting your breath, hot or cold spells, numbness or tingling in parts of your body, feeling weak in parts of the body, feeling tense and keyed up (8 items,  $\alpha = .92$ ). The response alternatives were on a five-point scale (0 = not at all, 1 = a little, 2 = neutral, 3 = quite much, 4 = very much).

### 2.3. Procedure

A link to the online questionnaire was placed on the main webpage of a city library. A paper-and-pencil version was also available, as well as a box where the questionnaires could be dropped anonymously. Furthermore, the link to the questionnaire was shared on social media as well as distributed to employees at a large workplace.

#### 2.4. Ethical Considerations

All respondents taking part in the investigation were anonymous. The study follows the ethical principles regarding scientific research with humans stipulated in the Declaration of Helsinki (World Medical Association, 2008) as well as guidelines for research by the Finnish Advisory Board on Research Integrity (2012).

### 3. Results

#### 3.1. Correlations between the Scales

For females, the four scales measuring social integration correlated significantly negatively with anxiety, depression, and somatisation (Table 2). The highest correlation for females was between satisfaction with the neighbourhood and low levels of anxiety. For males, the correlations were also significant except for those between somatisation and satisfaction with the neighbourhood and trust in the Finnish judiciary system. The highest correlation for males was found between positive social relations and low levels of depression.

Table 2

*Correlations for Females (n = 208) and Males (n = 90) between Four Scales Measuring Social Integration and Three Measures of Psychological Wellbeing*

<i>Social Integration</i>	<i>Psychological Wellbeing</i>					
	<i>Anxiety</i>		<i>Depression</i>		<i>Somatisation</i>	
	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>	<i>Males</i>
Access to Social Benefits	-.21 **	-.38 ***	-.15 *	-.36 ***	-.19 **	-.32 **
Satisfaction with the Neighbourhood	-.41 ***	-.24 *	-.37 ***	-.38 ***	-.29 ***	-.13 ns
Positive Social Relations	-.29 ***	-.38 ***	-.31 ***	-.42 ***	-.25 ***	-.30 **
Trust in the Finnish Judiciary System	-.23 ***	-.25 *	-.17 *	-.21 †	-.14 *	-.13 ns

*Note.* \*\*\*  $p \leq .001$ ; \*\*  $p < .01$ ; \*  $p < .05$ ; †  $p < .10$

#### 3.2. Sex Differences in Social Integration

A multivariate analysis of variance (MANOVA) was conducted with sex as independent variable, four scales measuring social integration as dependent variables, and age as covariate. The multivariate analysis was significant (Table 3). The univariate analyses showed that females scored significantly higher on access to social benefits, positive social relations, and trust in the Finnish judiciary system. No sex difference was found for satisfaction with the neighborhood. The mean values were overall high for both females and males (cf. Table 3).

Table 3

*Results of a Multivariate Analysis of Variance with Sex as Independent Variable, Four Scales Measuring Social Integration as Dependent Variables, and Age as Covariate (N = 289)*

	<i>F</i>	<i>df</i>	<i>p</i> ≤	$\eta_p^2$	<i>Females</i>		<i>Males</i>	
					<i>m</i>	<i>SD</i>	<i>m</i>	<i>SD</i>
Effect of Age as Covariate	25.49	4,	.001	.259				
		292						
Effect of Sex								

Multivariate Analysis	6.50	4, 292	.001	.082					
Univariate Analyses									
Access to Social Benefits	12.63	1, 295	.001	.041	3.40	0.51	3.14	0.74	
Satisfaction with the Neighbourhood	0.53	"	<i>ns</i>	.002	2.79	0.79	2.76	0.75	
Positive Social Relations	4.75	"	.030	.016	3.18	0.64	2.97	0.66	
Trust in the Finnish Judiciary System	10.32	"	.001	.034	3.25	0.54	3.00	0.76	

### 3.3. Age and Social Integration

A multivariate analysis of variance (MANOVA) was conducted with age group as independent variable and four scales measuring social integration as dependent variables. The multivariate analysis was significant (Table 4). The univariate analyses showed that respondents over 30 years of age reported significantly more positive social relations and more satisfaction with the neighborhood than respondents under the age of 30. No age differences were found for access to social benefits or for trust in the Finnish judiciary system (cf. Table 4).

Table 4

*Results of a Multivariate Analysis of Variance (MANOVA) with Age Group as Independent Variable and Four Scales Measuring Social Integration as Dependent Variables (N = 289)*

	<i>F</i>	<i>df</i>	<i>p</i> ≤	$\eta^2$	Age Groups					
					I <i>m</i>	<i>SD</i>	II <i>m</i>	<i>SD</i>	III <i>m</i>	<i>SD</i>
Effect of Age Group										
Multivariate Analysis	12.56	8, 566	.001	.151						
Univariate Analyses										
Access to Social Benefits	0.10	2, 285	<i>ns</i>	.001	3.28	0.67	3.32	0.54	3.32	0.61
Satisfaction with the Neighbourhood	43.23	"	.001	.233	2.52	0.78	2.44	0.72	3.22	0.60
Positive Social Relations	6.66	"	.001	.045	2.95	0.71	3.03	0.68	3.28	0.55
Trust in the Finnish Judiciary System	0.84	"	<i>ns</i>	.006	3.08	0.65	3.20	0.61	3.21	0.63

*Note.* I: 16–20 years; II: 21–30 years; III: 31–90 years

### 3.4. Social Integration and Psychological Wellbeing

The four scales measuring different aspects of social integration were added together and the sum was standardized. Two groups were created based on the total integration scores (high/low) with the standardized score 0 as demarcation line. A multivariate analysis of variance (MANOVA) was conducted with social integration group (high/low) as independent variable and three scales measuring psychological wellbeing as dependent variables. The multivariate analysis was significant (Table 5). The univariate analyses showed that respondents belonging

to the high social integration group scored significantly lower on anxiety, depression, and somatisation.

Table 5  
*Results of a Multivariate Analysis of Variance (MANOVA) with Social Integration Group (High/Low) as Independent Variable and Three Scales Measuring Psychological Well-being as Dependent Variables (N = 289)*

	<i>F</i>	<i>df</i>	<i>p</i> ≤	$\eta_p^2$	Social Integration Group			
					Low <i>m</i>	<i>SD</i>	High <i>m</i>	<i>SD</i>
Effect of Social Integration Group								
Multivariate Analysis	19.34	3, 294	.001	.165				
Univariate Analyses								
Anxiety	52.10	1, 296	.001	.150	0.97	0.87	0.35	0.60
Depression	43.40	”	.001	.128	0.87	0.82	0.31	0.63
Somatisation	25.68	”	.001	.080	0.76	0.86	0.33	0.63

#### 4. Discussion

The current study examined the role of social integration in determining subjective psychological wellbeing in a sample of the Swedish-speaking Finns in Ostrobothnia. It also examined sex and age differences in regard to integration. Social integration was in the study defined as a process during which an individual becomes a part of a particular group and has a sense of belonging to the immediate neighborhood (Ager & Strang, 2008). It refers to the extent to which one participates in a community's social activities and perceives oneself as an integrated member of that community (Brissette, Cohen, & Seeman, 2000). Quality social integration is one of the essential ingredients in contributing to individual's wellbeing and health. There is an established robust literature linking formal and informal social interactions to a better long-term mental health at the individual level and at a level of a collective nature of the society (Delhey & Dragolov, 2016; Holt-Lunstad, Birmingham, & Light, 2015). The quality relations may range from the most intimate partner relations to more remote connections such as engagement in the community work. All of the quality relations provide a sense of inclusion and belongingness that in turn promotes mental health and wellbeing (Durkheim, 1897).

The findings of the study showed that the respondents, both females and males, who had high scores on social integration had significantly lower scores on psychological symptoms. These results are in alignment with previous research (Suominen, Blomberg, Helenius, & Koskenvuo, 1999), and the results show clearly that social integration is associated with high levels of subjective psychological health and hence wellbeing in the minority group of Swedish-speaking Finns. Individuals in this population have been brought up in a cultural and social environment that adheres to egalitarianism, democracy, social integration, and inclusion. It values social progression, individualism as well as participation in the community (Kuisma, 2017; Vihriälä

& Valkonen, 2014). The promotion of a healthy society through equality in formal and informal settings, both at a state and grassroots level, is one of the factors influencing psychological health within the studied sample.

In this study, social integration was measured in formal and informal dimensions, including access to social benefits, satisfaction with the neighborhood, positive social relations, and trust in the Finnish judiciary system. The psychological wellbeing was measured in dimensions of anxiety, depression, and somatisation. In the case of the female respondents, a higher level of total social integration indicated lower levels of anxiety, depression, and somatisation. Thus, the strongest relationship was found between satisfaction with the neighborhood and low levels of anxiety. To female respondents, it is important to have friendly and hospitable relationships with neighbors, take part in social activities, and feel safe at home and in one's own community; all these contribute to low levels of anxiety. On one hand, these results are consistent with the results of a longitudinal study by Fothergill and colleagues (2011), affirming that among urban women, diverse and persistent engagement in the community predicts better health in comparison to non-engaged women. On the other hand, social engagement and social support can lead to psychological health issues, which is related to a question of conformity in traditional and minority settings (Corin, 1985), and especially is endorsed within rural environments (Brown & Harris, 1978).

For males, social integration indicated low levels of psychological symptoms as well, with the exception that satisfaction with the neighborhood and trust in the Finnish judiciary system did not have a significant association with somatisation. This means that for males, a sense of truly belonging to a neighborhood, being a part of and feeling at home in own community, trusting and respecting Finnish authorities and legal system, and a feeling of equality and freedom do not have any substantial implication in somatisation. This sex difference might be due to the fact that somatisation perhaps is a symptom which is more typical for females than males. Nevertheless, a feeling of being treated with respect by others within the same and different ethnic group contributed to their low levels of depression. Previous research on sex differences linking integration and health have mixed results depending on cultural and geographical background as well as social arrangements within the society (Pascall & Kwak, 2005; Pollert, 2005). A strong social integration can protect against depression; however, if the nature of social regulation within the society is repressive, a strong sense of integration may cause anxiety (Durkheim, 1897). Also, supportive and positive relationships may contribute to mental benefits for males but not for females, depending on sociocultural background (Dressler & Badger, 1985).

In the current study, when accounting for sex differences in social integration alone, the average scores were high for both males and females. Yet, such social integration dimensions as access to social benefits, positive social relations, and trust in the Finnish judiciary system, were higher for females. This suggests that in the current sample, it was more important for females than males to have an easy and equal access to public services, health care and education, as well as to have respectful interactions with others and the authorities. When it comes to such items as frequency of interaction with immediate neighbors, hospitality, and seeing Finland as one's true home, they were equally important for females and males.

When examining the relationship between age and the four dimensions of social integration, the results showed that age matters in the subjective experience of social integration. Respondents who were over 30 years old reported higher scores on positive social relations and satisfaction with the neighborhood than those under 30. The older respondents tended to be more satisfied with their neighbors and immediate neighborhood. They were happy to take part in social activities within the community, and they were pleased with their communication with

people from the same and different ethnic groups. To all respondents, regardless of age, access to social benefits and trust in the Finnish judiciary system were equally important. People of all ages tended to value easy and sure accessibility to public services, healthcare, education, and employment. Additionally, people at all ages were conscious about respecting and obeying laws and regulations, and they also felt that they received support from the society. These findings corroborate other results from community-based studies suggesting that social interactions become more positive and satisfying with age (Birditt & Fingerman, 2003; Lansford, Sherman, & Antonucci, 1998). This fact may be due to the approaches older adults use in their communication. For instance, they may apply principles of reciprocity, forgiveness, and everyday conflict resolution techniques that optimize positive social experiences (Field & Minkler, 1988; Luong, Charles, & Fingerman, 2011). There is a documented connection between social integration, health, and a late-life wellbeing. Frequent interaction with community members and engagement in community activities are associated with a decline of depressive symptoms, increased satisfaction in life, and subjective health (Fuller & Fiori, 2017). Interestingly, social integration and late-life health are reciprocal, meaning that subjective perception of health predicts multiple dimensions of social integration over time (Toyama, Toyama, & Fuller, 2019).

Social integration can be regarded as a resource for psychological health; in turn, psychological health can be regarded as a resource for social integration. Thus, psychological health promotion could be seen as a tool for individual and societal development. Simultaneously, promotion of social integration can be seen as a tool for improvement of psychological health. It begins with social and mental empowerment of a single individual that represents an autonomous personal resource at a collective level of a society. Through the focus on building social and mental health at the individual level, the wellbeing of a whole society can be improved. This further translates into high rankings of peacefulness and happiness as representations of citizens wellbeing at a state level in global comparisons.

The contribution of this study benefits those who are interested in building peaceful, inclusive, and healthy societies in order to enhance wellbeing for the communities and a state as whole. These, for instance, include state institutions, regional organizations, and community-based organizations at a grassroots level, whose scope is to promote sustainable social integration and improve quality and width of mental health wellbeing services.

In consideration of limitations and improvement of the current study, methodological aspects of the sample selection could be addressed. The size of the current sample could be larger in order to enable more rigorous analysis. Future research could focus on extending the population size within the region in question, and/or covering other Swedish-speaking parts in Finland. Also, future research could focus on longitudinal cohort studies that allow the possibility to address time-related factors such as developmental trends in the structure of population or changes related to economics and environment.

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