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Social Connectedness, Social Support and Life Satisfaction Among Adults Residing at Selected Urban Area, Chennai

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Abstract

Individuals aged 45 to 60 have several social and psychological obstacles that may diminish their sense of belonging, social support, and overall life happiness. This descriptive quantitative study assessed the social connectedness, perceived social support, and life satisfaction among 60 adults residing in Choolai, an urban locality in Chennai, Tamil Nadu, using non-probability convenience sampling. The Social Connectedness Scale (SCS), the Multidimensional Scale of Perceived Social Support (MSPSS), and the Life Satisfaction Questionnaire-11 (LISAT-11) were used to gather data. Results indicated that 68.33% of participants exhibited moderate social connectedness, whereas 36.67% reported low and moderate levels of social support, respectively. Nearly 71.67% exhibited low life satisfaction. Pearson correlation analysis confirmed statistically significant positive moderate correlations among all three variables ($r = 0.42–0.47$, $p = 0.01$). Chi-square tests revealed significant correlations between the study variables and sociodemographic factors, such as education, employment status, family structure, and monthly income. The study highlights the necessity for focused community-based initiatives to bolster social connectivity and increase psychosocial well-being in metropolitan adult populations.

Keywords: social connectedness; social support; life satisfaction; adults; urban Chennai; descriptive study.

1. Introduction

Adulthood, often encompassing the ages of 18 to 60, is characterised by increasing responsibilities in personal, professional, and social domains. While this phase of life brings maturity and independence, it

also carries a considerable psychosocial burden. Adults with work obligations, caregiving responsibilities, financial challenges, and evolving family dynamics frequently encounter significant limitations on their ability to engage in meaningful social interactions [1]. The recognised repercussions of this pressure include a gradual deterioration of social connections, significantly impacting mental health and overall quality of life.

Social connectedness, the perceived sensation of belonging and closeness with others has become a vital factor in adult well-being. People feel more lonely, anxious, and hopeless when this sense of connection is broken. In 2023, the U.S. Surgeon General released a report that said one out of every two adults said they felt lonely. This number is even more alarming because it is linked to health problems that are as bad as those caused by smoking or not exercising[2]. The Meta-Gallup State of Social Connections poll showed that about 24% of people around the world felt very or slightly lonely, even though 72% said they were well-connected. [3].

The concepts of social support includes the emotional, informational, and practical help that people get from their friends and family. This resource serves as a psychological buffer against stress by mitigating the adverse effects of negative circumstances and promoting positive behaviour. Many studies show that feeling like you have social support is linked to better mental health and less stress. Nonetheless, disparities in access endure: adults with lower incomes, individuals from marginalised communities, and those without formal education report significantly reduced levels of social support [4].

Life satisfaction, a cognitive evaluation of overall well-being, reflects how individuals gauge their lives against personal standards and expectations. It captures a wider sense of happiness than just temporary feelings. Data from international surveys suggest a U-shaped pattern over the lifespan, indicating that individuals aged 45–59 exhibit the lowest average satisfaction levels globally. This finding underscores midlife as a period of considerable psychosocial susceptibility. [5]. Urban areas, despite having a lot of infrastructure and chances, tend to break up social groups. Job markets that are too competitive, places to live that are too crowded, and traditional community institutions that are losing power all make it harder to have real social interactions. This contradiction is especially clear in Indian cities like Chennai, where rapid urbanisation has created jobs but also broken down the traditional joint family systems that used to serve as safety nets [6].

Social connectedness, social support, and life satisfaction are well-established constructs; however, there is a paucity of integrated assessments in the Indian context that investigate the interrelationships of these three factors within a particular adult community. This research addresses that deficiency. This study seeks to delineate the psychosocial landscape of middle-aged adults by concurrently analysing three variables within an urban community in Chennai, while also identifying the sociodemographic factors that influence their experiences. The insights generated are intended to inform nursing practice, community health programming, and policy directed towards enhancing adult well-being.

2. Materials and Methods

A quantitative, descriptive research design was employed. The research was carried out in Choolai, an urban area in Chennai, Tamil Nadu, India. The target population comprised all adults between 45 and 59 years of age residing in Choolai, Chennai. Sample size was calculated using the formula based on a reference proportion of 42.6% social support from a prior study [7], with 95% confidence and 30% relative

precision, yielding a minimum requirement of 58 participants, rounded to 60. Participants were chosen through non-probability convenience sampling, contingent upon their availability and willingness to engage. The inclusion criteria mandated that participants be aged 45 to 60 years, reside in Choolai, possess comprehension of Tamil or English, and be willing to provide informed consent. Individuals exhibiting cognitive impairments, severe mental disorders, or critical illnesses during the data collection phase were excluded. Data were collected using sociodemographic questionnaires, the Social Connectedness Scale (SCS), developed by Lee and Robbins (1995) [8], the Multidimensional Scale of Perceived Social Support (MSPSS), developed by Zimet et al. (1988) [9] and the Life Satisfaction Questionnaire-11 (LISAT-11), developed by Fugl-Meyer et al. (2002) [10].

Ethical approval was secured from the Institutional Ethical Committee before commencing data collection. Written authorisation was obtained from the Block Medical Officer of the study area. All participants were apprised of the study's objectives, methodologies, and their entitlement to withdraw at any moment without repercussions. Informed agreement was obtained from each participant, and personal data were maintained under strict confidentiality and utilised solely for study reasons. No physical, emotional, or psychological harm was caused to any participant throughout the process. A pilot study was carried out with 10% of the total sample (n = 6) to assess the feasibility and clarity of the instruments. These participants were subsequently excluded from the primary data collection. The pilot results showed that the tools and the way the data were collected were both useful.

To make sure that everyone could communicate clearly and take part, each person was approached one at a time, told about the study, and asked to fill out the instruments while the researcher was there. Finalised data were inputted into Microsoft Excel and later uploaded to SPSS (version 26.0) for statistical analysis. A p-value below 0.05 was deemed statistically significant.

3. Results

3.1 Sociodemographic Profile of Participants

A total of 60 adults participated in the study. The majority (58.34%) were in the 45–49 years age group. Female participants predominated (73.33%), and 90% were married. Educational attainment was generally low, with 38.33% having received no formal education and 28.33% having completed only primary school. Self-employment and retirement were equally common in terms of jobs, with each making up 23.33% of the total. Almost half (46.67%) had a monthly household income below ₹10,000. Most participants lived in nuclear families (55%), had two children (35%), and identified as Hindu (61.67%). Physical activity was predominantly sedentary (43.33%) or light (45.00%), and 35% did not use social media. The majority (65%) reported no comorbid conditions. Table 1 summarises the demographic distribution.

Table 1. Sociodemographic variables of the study participants (n = 60)

Demographic Variable	Category	n	%
Age (years)	45–49	35	58.34
	50–54	11	18.33
	55–59	14	23.33

Gender	Male	14	23.33
	Female	44	73.33
	Other	2	3.33
Marital Status	Married	54	90.00
	Widowed	4	6.67
	Single/Divorced	2	3.33
Education	No formal education	23	38.33
	Primary school	17	28.33
	Secondary school	5	8.34
	Higher secondary	2	3.33
	Graduate and above	13	21.67
Monthly Income (INR)	< ₹10,000	28	46.67
	₹10,001 – ₹30,000	26	43.33
	₹30,001 – ₹50,000	6	10.00
Family Type	Nuclear	33	55.00
	Joint	20	33.33
	Extended	7	11.67

3.2 Level of Social Connectedness

The mean score of social connectedness across participants was 72.38 (SD = 16.02), representing 60.32% of the maximum possible score. In terms of overall level classification, 68.33% of participants were in the moderate category, 16.67% showed low social connectedness, and only 15.00% demonstrated high social connectedness. Table 2 presents these levels.

Table 2. Level of social connectedness among adults (n = 60)

Level	**n**	**%**
Low	10	16.67
Moderate	41	68.33
High	9	15.00
Total	**60**	**100.00**

3.3 Level of Social Support

The overall mean score of perceived social support was 45.00 (SD = 20.67), equivalent to 53.57% of the maximum. Among the participants, 36.67% were classified as having low social support and an equal proportion (36.67%) as moderate. Only 26.66% reported high levels of perceived social support, as presented in Table 3.

Table 3. Level of perceived social support among adults (n = 60)

Level	n	%
Low	22	36.67
Moderate	22	36.67
High	16	26.66
Total	**60**	**100.00**

3.4 Level of Life Satisfaction

The mean life satisfaction score was 31.01 (SD = 10.64), corresponding to 46.98% of the maximum possible score. About 71.67% of participants scored in the low satisfaction range, 23.33% in the moderate range, and only 5.00% demonstrated high life satisfaction. (Table 4).

Table 4. Level of life satisfaction among adults (n = 60)

Level	n	%
Low (11–24)	43	71.67
Moderate (25–39)	14	23.33
High (40–66)	3	5.00
Total	**60**	**100.00**

3.5 Correlation Between Social Connectedness, Social Support, and Life Satisfaction

Pearson correlation analysis was performed to examine the relationships among the three study variables. The results are presented in Table 5.

Table 5. Pearson correlation between social connectedness, social support, and life satisfaction

Variable Pair	Mean ± SD	r	p-value
Social Connectedness vs. Social Support	72.38±16.02 / 45.00±20.68	0.45	0.01 (S)
Social Connectedness vs. Life Satisfaction	72.38±16.02 / 31.02±10.64	0.42	0.01 (S)
Social Support vs. Life Satisfaction	45.00±20.65 / 31.02±10.64	0.47	0.01 (S)

S = Statistically significant at $p < 0.05$

All three correlations were statistically significant (p = 0.01), confirming that higher social connectedness is associated with both greater social support and better life satisfaction, and that stronger social support similarly predicts higher life satisfaction.

3.6 Association with Sociodemographic Variables

Chi-square tests indicated a significant association between social connectedness and educational status ($\chi^2 = 13.78$, p = 0.01) as well as employment status ($\chi^2 = 13.15$, p = 0.05). Individuals possessing secondary education or higher, as well as those engaged in formal employment or retired, exhibited significantly elevated levels of connectedness in comparison to individuals lacking education or those who were unemployed.

Perceived social support exhibited a highly significant correlation with educational status ($\chi^2 = 18.43$, p = 0.001) and a significant correlation with family type ($\chi^2 = 9.37$, p = 0.01). Adults residing in joint families consistently indicated elevated levels of support compared to those in nuclear or extended families, thereby underscoring the protective function of multigenerational living arrangements.

There was a strong link between life satisfaction and both educational level ($\chi^2 = 13.69$, p = 0.001) and monthly income ($\chi^2 = 8.16$, p = 0.05). People who made more money and had more than a primary school education said they were happier with their lives. Other sociodemographic factors such as age, gender, marital status, religion, physical activity level, social media usage, and comorbidity did not exhibit statistically significant correlations with any of the three study variables.

4. Discussion

Results show that middle-aged urban residents in Chennai have serious psychological and social problems, especially in the areas of satisfaction and social support. The majority reported moderate social connectedness, the strikingly high prevalence of low life satisfaction (71.67%) and the near-equal distribution of low and moderate social support suggest that emotional and social resources are thinly distributed in this population.

The moderate level of social connectedness observed in this study aligns with global patterns. A nationally representative U.S. study found that while most older adults continued to maintain some social contact, the quality and frequency of those interactions declined significantly during periods of social disruption, with in-person interactions being a stronger predictor of connectedness than digital ones [11]. The present data similarly suggest that while most participants reported some degree of interpersonal engagement, deep relational ties—the kind that generate a genuine sense of belonging—were less common, as evidenced by lower scores on items reflecting brotherhood, sisterhood, and comfort among friends.

The findings of social support that 36.67% of participants experienced low support is consistent with evidence from Ethiopia, where approximately 30.7% of adults were found to have inadequate social support [12]. It is also consistent with a comprehensive cross-sectional study conducted in the United States, which revealed that diminished social support was associated with elevated rates of depressive symptoms and suboptimal health behaviours, particularly among economically disadvantaged populations [13]. In the present study's sample, with nearly half of the participants earning less than ₹10,000 per month,

economic vulnerability likely exacerbates social vulnerability in manners that formal support networks are inadequately equipped to address.

The significant incidence of low life satisfaction corresponds with a study from India that found mean life satisfaction scores among urban adults to be substantially lower than those of their rural or semi-urban counterparts, especially among individuals lacking higher education or a stable income [14]. Mandi et al. conducted a study that identified self-rated health, functional ability, and mental health status as the most significant predictors of life satisfaction among older Indian adults, while socioeconomic disparities continued to be a consistent determinant [15]. This study contributes to the existing literature by demonstrating a significant correlation between education, income, and life satisfaction in an urban South Indian context.

The moderate positive correlations between social connectedness and social support ($r = 0.45$), social connectedness and life satisfaction ($r = 0.42$), and social support and life satisfaction ($r = 0.47$) indicate a clear and mutually reinforcing relationship among these constructs. These results are consistent with Avci's (2023) findings, which demonstrated that social connectedness exerts both a direct and mediated effect on life satisfaction through its influence on belongingness [16]. In a similar context, a study by Friedman et al. (2024) employing longitudinal data confirmed that individuals with strong social connections experienced slower functional decline and enhanced longevity, suggesting that the benefits of connectedness extend beyond psychological well-being [17].

The significant impact of education on all three variables necessitates consideration. In this sample, a substantial proportion of participants either lacked formal education or had only completed primary school, and these cohorts consistently exhibited reduced levels of connectedness, support, and satisfaction. Education appears to function as a social facilitator by enhancing access to information, creating employment opportunities, and aiding individuals in acquiring the social competencies essential for meaningful relationships. The connection between joint family structure and more social support backs up the idea that relationships are very important for mental health in India. When it works, the joint family provides an internal social network that makes up for the lack of formal support systems.

When considered collectively, these results indicate that enhancing adult psychosocial well-being in urban India requires focused interventions that address social isolation, educational disadvantage, and income insecurity. Community health nurses are especially well-positioned to foster peer support networks, identify individuals who are at risk, and push for structural changes that bolster social safety nets.

5. Conclusion

The majority of participants exhibited moderate social connectedness, while low to moderate social support and predominantly low life satisfaction were the defining characteristics of the sample. There were strong positive links between all three variables, and education, job status, family type, and monthly income were found to be the most important sociodemographic factors. These findings strengthen the idea that psychosocial well-being in midlife is not merely an individual issue but is profoundly affected by structural factors, such as the quality of education, the nature of employment, the dynamics of family life, and the availability of economic resources. For community health practice, the implications are clear: screening adults for social disconnection and low life satisfaction should be integrated into routine nursing assessments, and interventions that promote community cohesion, peer support, and family resilience

should be prioritised. Future research should employ larger, multi-site samples and longitudinal designs to track how social connectedness and support evolve across the adult lifespan and in response to targeted community-based programmes.

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