

The relationship of perceived social support with subjective well-being and quality of
life among inmates

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Abstract

Incarceration in a prison causes drastic changes in the lives of inmates, forcing them to adapt their personal resources, in order to deal with emotional challenges, as well as new social and institutional rules. The adaptation process gains efficiency when there is effective social support (SS), allowing for better quality of life (QOL) for inmates. Subjective well-being (SWB) and, above all, positive affective experiences have a positive and cumulative influence on the individuals' well-being, having an important role in improving QOL. The aim of this study is to examine the relationship between perceived social support (PSS) and SWB and QOL in inmates. The sample consists of 55 male inmates from two regional prisons in northern Portugal, with a mean age of 41 years. The instruments used were the Multidimensional Scale of Perceived Social Support, the Positive and Negative Affect Schedule and the WHO Quality of Life-BREF (WHOQOL-BREF). From the legal-criminal profile, most inmates are primary, with prison time of 1 to 5 years, and a sentence to still be completed of between 2 and 5 years, they have a reasonable relationship with other inmates and a very good relationship with the prison staff. A significant correlation was found between PSS of significant others with all dimensions of QOL, between PSS and QOL, and between the total dimension of SWB and the general and psychological dimensions of QOL. The PSS is lower than that of the general population and inmates with greater PSS experience positive affect more frequently. Data is discussed and implications for working with inmates in prison are suggested.

Keywords: inmates, perceived social support, subjective well-being, quality of life.

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The impact of incarceration and deprivation of liberty among inmates is reflected at the individual, systemic and social levels. Social support (SS) and contact networks may, therefore, be affected and, sometimes, the interactions that existed previously may end up suffering disruptions, since the family is subjected to an emotional strain that, occasionally, can lead to the abandonment of individuals. However, when structured, family ties can play a rehabilitating role during the prison journey of individuals and, through visitations, the “losses” with the outside world are minimized and affective ties are maintained, that is, they are a protective factor contributing to well-being (WB), thus improving the quality of life (QOL) of inmates.

Social Support

Social support has been widely studied as a health promoting factor (Dunbar et al., 1998), with contributions by Cassel (1974), who tried to understand the nature and protective effects of SS, and Caplan (1974), who clarified the nature of SS in the primary group and its importance for the WB of individuals. Cobb (1976) conceptualized SS as a buffer for stress, taking on the role of facilitating confrontation and adaptation in crisis situations.

Sarason, Levine, Basham and Sarason (1983) defined the SS as “the existence or availability of people who can be trusted, people who show us that they care about us, value us and like us” (p.127), with the support network and fundamental social relationships for the individual being created and represented by family, friends, neighbors or other significant people.

Similarly, still regarding the different sources of SS, Dunst and Trivette (1990) distinguished informal SS and formal SS. Informal social networks, in response to normative and non-normative life events, are able to provide support in everyday

activities and include family, friends, neighbors, and social groups such as clubs, associations and the church, among others. Formal social networks have the function of providing assistance to people or social groups who need it most, and includes formal social organizations, such as hospitals, government programs, health services and health professionals.

The protective role of SS in adverse situations, which require the individual to use mechanisms of adaptation and to overcome stressful events (Zimet, Dahlem, Zimet, & Farley, 1988), is very evident when entering a prison. Since deprivation of liberty is an impactful experience (Gomes, 2008), in a prison environment, individuals undergo a reframing and re-adaptation of experiences, intrinsic and extrinsic to the prison environment; however, external references are those that continue to be maintained, such as their family, profession or home (Cunha, 1994).

Nonetheless, the segregation of inmates, in relation to society, promotes the removal of family and affective bonds, conditioning the inmate to adaptive behaviors towards the norms and rules that prevail in the prison system (Faustino & Pires, 2009), as well as to a greater probability of recidivism (Medeiros, 2010; Williams, 1999).

Thus, for an inmate to experience a more adaptive prison trajectory, which can be reflected in their future social reintegration, it is important that institutions provide the inmate with contact with the outside environment. Therefore, SS will be able to promote self-esteem and feelings of control over the environment, creating positive emotional experiences (Pearlin, Lieberman, Menaghan, & Mullan, 1981).

According to the literature, SS provided by the family is considered the most important, in the incarceration process (Freitas, 2008). The absence of family support has raised concerns among some researchers, who say that a gap in the protective role of the family can trigger negative consequences in the re-socialization process of inmates after

serving their sentence (Almeida, Duarte, Fernando, Sousa, & Abreu, 2003; Oliveira & Lima, 2013). It is within the family that individuals can share their feelings, emotions, fears and problems in an affectionate way, thus, the absence of this support in the prison context may lead to complications, for example, rejection, low self-esteem and loneliness, which may remain after completion of the sentence (Rocha & Silvério, 2005).

According to Rodriguez and Cohen (1998), SS is capable of generating beneficial effects for the physical and mental health of individuals, establishing a close relationship with WB. Indeed, the literature suggests that, in the prison environment, visits are described as a moment that provides affective bonds and feelings of overall WB, and consequently a greater expression of positive feelings in the inmate (Dixey & Woodall, 2011; Duncan & Balbar, 2008; Gomes, Duarte, & Almeida, 2003). Visits have been the subject of several studies that suggest the protective effect of long-term social ties, that is, visits received by inmates seem to help reduce and delay their recidivism in the criminal world (Bales & Mears, 2008; Duwe & Clark, 2013).

According to Visher and Travis (2003), inmates' processes of adaptation to prison will also be a predictor of future successful reintegration, therefore, this will not only depend on the characteristics intrinsic to the individual, but also on the socio-environmental context, that is, community involvement and maintaining relationships with family and peers. However, they warn that these protective factors can simultaneously be risk factors for the reintegration and post-prison adjustment of individuals.

Regarding inmates' perception of SS in prison, Novais, Ferreira and Santos (2010) define three major categories, namely: (i) good relationship with all members; (ii) a healthy relationship with only one individual; and (iii) inmates who feel they are not supported by anyone, be they other inmates or prison guards. Thus, it should be noted

that adjustment to the prison environment is dependent not only on individual factors, but also on the quality of the relationships the individual has established with their family and social support network (Gomes, 2008; Novais et al., 2010).

A qualitative study of a visitation center in the United Kingdom, by Woodall, Dixey, Green and Newell (2009), regarding a health promotion program focused on the quality of visits, found that, indeed, this type of approach allows to support families and inmates, by improving the quality of visits, which is reflected in the importance of maintaining family ties for reintegration and, consequently, reducing recidivism behaviors.

Concerning the SS provided by visits, Cochran (2012) found that inmates who receive visitors have lower rates of misconduct during the period of incarceration, allowing inmates to create friendships (Duncan & Balbar, 2008) and increasing their WB (Listwan, Colvin, Hanley, & Flannery, 2010).

As for inmates' perspectives regarding reintegration, Davis, Bahr and Ward (2012), using the interview as a method of accessing these perceptions, concluded that, overall, inmates mentioned the importance of social support from family, friends and treatment services provided by the prison, as motivational factors and predictors of successful reintegration and removal from the world of crime. Similarly, another study, by Brosens, Donder, Vanwing, Dury and Verté (2014), demonstrated the existence of a positive relationship between the importance of social networks and the interactions established with family and friends, as a factor in making the decision to participate in learning activities for the future life of inmates.

Subjective Well-Being

SWB is seen as a multidimensional construct, consisting of two components, the affective component (positive and negative affect), and the cognitive component, which

refers to the global assessment of life satisfaction (Deci & Ryan, 2008; Diener, Oishi, & Lucas 2003; Diener, Sapyta, & Suh, 1998; Galinha, 2008; Galinha & Pais-Ribeiro, 2005b; Keyes, Shmotkin, & Ryff, 2002).

Currently, most researchers accept that affection is the emotional component of SWB (Diener et al., 1999). According to Galinha and Pais-Ribeiro (2005b), SWB is defined as a positive dimension of health, and is a complex concept that integrates a cognitive dimension and an affective dimension. These authors argue that, in addition to cognitive and affective factors, contextual factors (such as age, gender, marital status, education, employment), as well as positive and negative events in the individuals' lives, are also related to SWB (Galinha, 2008; Galinha & Pais-Ribeiro, 2011).

According to Sirgy (2002), the concept of SWB is integrated as part of the assessment of QOL and is defined as a lasting affective state (long-term), which comprises three components: the accumulated experience of positive affect, the accumulated experience of negative affect, and the assessment of overall satisfaction with life. It should be taken into consideration that satisfaction with life, positive affect (emotions such as joy, affection and pride) and negative affect (emotions such as shame, guilt and sadness), happiness and SWB are subjective aspects of QOL.

In the literature, positive affect has been described as an emotional indicator that produces health and WB, and since the experience of positive affect is accumulated, this has repercussions on the growth and resilience of individuals (Fredrickson, 2001; Fredrickson & Losada, 2005).

Regarding the hypothesis of the direct effect of SS, Broadhead and colleagues (1983) argue that it can bring immediate beneficial effects, regardless of the levels of stress or personal problems the individual experiences, that is, SS always promotes health and WB.

From another perspective, Cohen and McKay (1984) explored the buffering hypothesis, where they proposed that SS intervenes in reducing stress and, in relation to stress-inducing events, consequently, it has a protective/buffering effect, providing a contribution to alleviate or prevent the responses of individuals to the impact of stress. Thus, in the face of a stress-inducing situation, either directly or indirectly, two distinct consequences can be observed: the first, in which high SS is associated with low psychological distress; and the second, which concerns the protective, buffering and moderating function SS has towards the detrimental effects on the WB of individuals. In contrast, low SS points to harmful consequences of stress (Martins, 2005).

Several authors (Myers, 2000; Tay & Diener, 2011; Tay, Kuykendall, & Diener, 2015) found that satisfactory social relationships contribute to the promotion of individuals' SWB. The systematic review made by Lyubomirsky, King and Diener (2005), using meta-analysis and integrating several types of studies (transversal, longitudinal and experimental), also concluded that high levels of SWB were associated with SS.

Other studies indicate satisfaction with life as a fundamental component of WB (Diener, Emmons, Larsen, & Griffin, 1985; Diener et al., 1999), that is, the cognitive assessment individuals make of their own SWB which, in turn, is associated with the social support received, and individuals who present higher levels of satisfaction with life report having social support (Kong, Ding, & Zhao, 2014; Kong, Zhao, & You, 2012; Newsom & Schulz, 1996; Pinquart & Sörensen, 2000; Siedlecki, Salthouse, Oishi, & Jeswani, 2014; Song, Kong, & Jin, 2013). Research has shown that individuals who experience better quality social support networks, consequently, experience less distress and greater SWB (Gallagher & Vella-Brodrick, 2008; Kong & You, 2013; Montes-Berges & Augusto, 2007).

In a prison context, perceived SWB is influenced by individual, relational and contextual variables. Laan and Eichelsheim (2013), in their study, reported that daily activities in prison were associated with positive adaptation, providing inmates with feelings of safety, autonomy and WB.

Crewe, Liebling and Hulley (2011) identified contextual and personal factors involved in inmates' WB, such as: the characteristics of the prison and the material conditions it provides, as well as the attitudes and behavior of the prison staff towards the inmates, which are determinant for QOL. Another study addresses that QOL in prison can be influenced by the absence or presence of the use of authority by prison staff over inmates (Crewe, Liebling, & Hulley, 2014).

Incarceration itself brings with it a set of deteriorating effects on individuals; however, emotional effects influence the WB of individuals, since they must have emotional control that does not allow them to express their emotions, rather, controlling them and weakening relationships and social interactions (Haney, 2001).

Harreveld, van der Pligt, Claassen and van Dijk (2007) concluded that coping centered on emotions may help the SWB of inmates, but for this to happen, it is necessary to share emotions, both among the inmates themselves and with their families, that is, the individuals' SS network has a beneficial effect, allowing them to actively deal with negative feelings by sharing them. A gap in the social network suggests that inmates may experience feelings of loneliness and, consequently, low levels of WB. The study also showed that inmates who share their negative emotions with others are in better health than those who keep their emotions to themselves (Harreveld et al., 2007).

According to a study by Kaap-Deeder and colleagues (2017), giving inmates the possibility of any kind of choice over their lives, such as the possibility of leisure, work and education activities, is reflected in their WB, that is, the perception of the individuals

about their choices enables them, in some way, for greater satisfaction with their autonomy, promoting positive levels of SWB, so important in prison.

A recent study by Arriola et al. (2015) reflects the importance of SS in the issue of the health of individuals, with results indicating positive effects on the improvement of WB in incarcerated individuals. A systematic literature review by Claire and Dixon (2015) emphasizes the beneficial effect of visits on inmates' WB, highlighting the importance of SS for inmates, as well as the reduction of disruptive behaviors and recidivism (Bales & Mears, 2008; Cochran, 2012).

Quality of Life

The World Health Organization (WHO) defines QOL as “the individuals' perceptions of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (World Health Organization Quality of Life [WHOQOL Group], 1994, p.28). Similarly, Cramer (1994) also defined QOL as physical, mental and social WB, complete, and not just the absence of an illness. According to Shumaker, Anderson and Czajkowski (1990), QOL can be defined as the “global individual satisfaction with life and general, personal, well-being” (p.96).

QOL has been positively related to SS. For Panayiotou and Karekla (2012), the main role of SS is to instill, in individuals, feelings of belonging, appreciation, to make them feel loved and that they are part of a communicative system of exchange and mutual obligations, thus having impact on the QOL and stress experienced.

Luszczynska, Pawlowska, Cieslak, Knoll and Scholz (2013) found there are significant differences in the association between the various dimensions of QOL and SS, and that different sources and types of social support have greater prediction in QOL.

This corroborates that SS provided by family, friends and health professionals is more significant for individuals, improving their QOL.

For inmates, it is important that prisons be able to play a role in re-education, resocialization and reintegration into society and, imperatively, provide them with a good QOL during this period. Regarding inmates' perceived QOL, this will result from the successive interiorizations that individuals make of the perceptions they had in their daily lives (Cuervo-Arango, 1993).

Inmates' perceived QOL, according to Novais et al. (2010), varies, regardless of age, according to the relationships with others (guards or inmates) and to the positive adaptation to the environment and conditions. The authors also refer that perceived QOL is reflected in the perceived quality of relationships, that is, when they perceive lower quality relationships, interactions will be less positive and adaptation will be difficult.

It should be noted that individuals' acceptance of the new reality is also variable, and this variability can be determined by the SS provided to individuals by professional staff, that is, there is a positive impact on inmates' adaptation to life in prison when they have support from prison staff, and the lack of social support inside and outside the prison could lead to inmates evidencing misconduct during incarceration and may have repercussions after release (Mesko & Hacin, 2018).

Regarding the social representations that prison guards and members of leadership have regarding inmates and their relationship with the prison environment, stereotyped perceptions stand out, which influences, in itself, the adaptation to the prison context (Gomes, 2012).

Currently, according to the Report on the Prison and Guardianship System (XXI Constitutional Government, 2017), the diagnosis conducted of prisons points to a "severe situation of overcrowding" (p.119) and the worsening of health conditions (Albino,

2007). A multilevel study, by Molleman and Ginneken (2014), on cell sharing and its influence on QOL in prison, showed that sharing is associated with lower perceived QOL, which is also influenced by the reduced quality of the relationships between inmates and prison staff.

The present study

Having analyzed the literature, it is possible to state that SS is a protective source for individuals in challenging situations, such as incarceration. Consequently, SS contributes to improving WB, that is, the higher the SS, the lower the distress, and the greater the perceived QOL. On the other hand, the lower the SS, the greater the incidence of problems that, consequently, affect the physical and psychological health of individuals, deteriorating their WB and QOL. However, this hypothesis has not yet been tested with the prison population.

Therefore, since entering prison leads to individual and behavioral changes, as well as changes in family dynamics, which must adapt to the new demands of life, it is pertinent to study the influence of SS on inmates' lives and the effects that it has on their WB and, consequently, their perceived QOL.

As such, the starting point for this research is the following question: "To what extent is social support related to inmates' subjective well-being and quality of life?"

Thus, based on the general objective of evaluating the role of PSS in the SWB and QOL of inmates, the following specific objectives emerge: (i) to understand the legal and criminal dimensions of inmates; (ii) to characterize the dimensions of SS, perceived SWB and QOL; and (iii) to understand the relationship of SS with perceived QOL and SWB.

Method

The present research is a cross-sectional correlational study, with a quantitative design.

Participants

Fifty-five male inmates from two regional prisons, located in the territorial area of northern Portugal, aged between 23 and 78 years ($M=41.0$; $SD=12.8$; $N=55$) participated in the study (Table 1). Regarding inmates' nationality, 96.4% have Portuguese nationality and 3.6% have foreign nationality (French and Spanish).

Regarding marital status, in the two prisons, 52.7% of inmates are single, 23.6% are divorced, 16.4% are married and 7.3% are in de facto unions. Regarding educational levels, overall, most inmates have the 2nd or 3rd cycle of education (69.8%), 3.8% cannot read or write, 5.7% have the 1st cycle, 13.2% have high school education and 7.5% have higher education.

As for employment status before incarceration, 67.3% of inmates worked before incarceration, 7.3% never worked, 21.8% were unemployed and 3.6% were retired. Concerning how their work was performed, most inmates were employed by others (58.3%), 35.4% were self-employed and 6.3% were, cumulatively, self-employed and employed by others. As for children, 61.8% of inmates have children and 38.2% do not have children. Regarding the number of children of inmates who have them, overall, most have one child (47.1%), 29.4% two children, 17.6% three children, 2.9% four children and 2.9% six children ($M=1.88$; $SD=1.12$).

Table 1.

Sociodemographic data

Age	N	(%)
23-29 years	12	(21.8)
30-39 years	15	(27.3)
40-49 years	16	(29.1)

50-59 years	8	(14.5)
60-69 years	2	(3.6)
70-78 years	2	(3.6)
Gender	n	(%)
Male	55	(100.0)
Female	0	(0.0)
Nationality	n	(%)
Portuguese	53	(96.4)
Foreign	2	(3.6)
Marital status	n	(%)
Single	29	(52.7)
Married	9	(16.4)
De facto union	4	(7.3)
Divorced	13	(23.6)
Education levels	n	(%)
Does not read, nor write	2	(3.8)
1st cycle	3	(5.7)
2nd cycle	18	(34.0)
3rd cycle	19	(35.8)
High school	7	(13.2)
Higher education	4	(7.5)
Employment status	n	(%)
Was working	37	(67.3)
Has never worked	4	(7.3)
Unemployed	12	(21.8)
Retired	2	(3.6)
Type of employment	n	(%)
Self-employed	17	(35.4)
Employed by others	28	(58.3)
Both	3	(6.3)

Existence of children	n	(%)
Without children	21	(38.2)
With children	34	(61.8)
Number of children	n	(%)
1 child	16	(47.1)
2 children	10	(29.4)
3 children	8	(17.6)
4 children	1	(2.9)
6 children	1	(2.9)
Total	55	(100.0)

Note. Min. – Minimum; Max. – Maximum; M – Mean; SD – Standard deviation.

Instruments

Sociodemographic questionnaire. The collection of demographic data (age, marital status, nationality) and legal and criminal data (primary, recidivism, number of arrests, type of crime) was carried out through the application of a sociodemographic questionnaire.

Social support. The Multidimensional Scale of Perceived Social Support (MSPSS), by Zimet et al. (1988), was translated and adapted by Carvalho et al. (2011). The MSPSS assesses the perceived SS of each individual, and consists of 12 items, divided into three dimensions: family, friends and significant others. Family encompasses items 3, 4, 8, 11; friends includes items 6, 7, 9, 12; and significant others, which may be any source external to family and friends (Canty-Mitchell & Zimet, quoted by Carvalho et al., 2011), includes items 1, 2, 5, 10. In this last subscale, the significant others are defined by the individuals who respond to the scale (Carvalho et al., 2011). The scale is a seven-point Likert-type scale, from 1 (Strongly Disagree) to 7 (Strongly Agree). The MSPSS scale is a simple tool to apply, its items are easily understandable and, therefore,

indicated for individuals with a 4th-grade level education, who do not tolerate long questionnaires (Carvalho et al., 2011). The sample consists of three groups: a group of students ($N=454$), with a total mean of ($M=5.94$); a group from the general population ($N=261$), with a total mean of ($M=5.87$) and, a group of patients with major depression ($N=100$), with a total mean of ($M=4.68$). The means of the four subscales for the general population are as follows: MSPSS-Family ($M=5.98$); MSPSS-Friends ($M=5.49$); MSPSS-Significant Others ($M=6.16$) and MSPSS-Total ($M=5.87$). The scale has good internal consistency (Cronbach's alpha), between 0.85 and 0.95, considering the three subscales and the three groups. The cutoff point of the scale is 5.

Subjective well-being. The Positive and Negative Affect Schedule (PANAS) by Watson et al. (1988), translated and adapted for the Portuguese population by Galinha and Pais-Ribeiro (2005a), was administered. The PANAS assesses the affective dimension (trait or state) of SWB, the positive affect and the negative affect. It consists of 20 items, 10 with positive valence (items 1, 3, 5, 8, 10, 11, 13, 15, 17, 19) and 10 with negative valence (items 2, 4, 6, 7, 9, 12, 14, 16, 18, 20). Each item is answered on a Likert scale from 1 (very slightly or not at all) to 5 (extremely). The scale sample consists of university students ($N=348$), of which 161 are women, with a mean age of ($M=20.33$), varying between 18 and 50 years, and by 177 men, with a mean age of ($M=20.86$), varying between 18 and 40 years. The Cronbach's alpha coefficient for the scale, in the Portuguese version of positive affect, is 0.86, whereas for negative affect, the significance level of the scale is 0.89. As for the correlation between the positive and negative affect dimensions, for the Portuguese version, it is -0.10, that is, it is expected to be close to zero, establishing the independence between the two dimensions of affect. The cutoff point of the scale is 3.

Quality of Life. The instrument used to assess QOL was the WHOQOL-Bref from the WHO, translated and adapted into Portuguese by Vaz Serra et al. (2006). It consists of 26 questions, two more general questions related to overall perceived QOL and to overall perceived health, and the remaining 24 represent each of the 24 specific facets that constitute the original instrument (WHOQOL-100). In the WHOQOL-Bref, each of the 24 facets is evaluated by only one question on a satisfaction or agreement scale with 5 levels, maintaining the subjective and multidimensional essence of the QOL concept. WHOQOL-Bref is organized into four domains: physical, psychological, social relations and environment. The instrument sample consists of a total of ($N=604$), one group being from the general population ($N=315$) and one group belonging to the clinical population ($N=289$). The means of the four domains are as follows: physical domain ($M=71.50$); psychological domain ($M=69.30$); domain of social relations ($M=69.90$) and, finally, the environment domain with a mean value of ($M=63.58$). The instrument has good internal consistency indexes, and when considering the set of domains, Cronbach's alpha coefficient is 0.79, and the 26 items that make up the instrument have a significance level of 0.92. As for correlations between the four domains, the WHOQOL-Bref, in the Portuguese version, presents high correlations between 0.77 and 0.86, for the domain of social relations and for the psychological domain, respectively. The cutoff point of the questionnaire is 60.

Procedures

For data collection, an authorization request to conduct the study was sent to the Directorate-General for Reintegration and Prison Services (DGRSP) and was accepted. Subsequently, the prisons were contacted and granted access to the participants.

With each participant, the Informed Consent was explained and signed, describing the objective of the study, the necessary instructions, its voluntary nature, as well as the anonymity and confidentiality of the data, underlying the rules and values of the Code of Ethics of the Order of Portuguese Psychologists. Subsequently, the instruments were administered, in a single moment, with each participant.

For data analysis, a database was developed for descriptive and inferential analysis, using the IBM SPSS® (*Statistical Package for the Social Sciences*). Descriptive statistics were used for the analysis of demographic and legal-criminal data. Correlation analyses were performed to verify the relationship between the variables, in order to answer the objectives of the study.

Results

Descriptive analysis of the legal and criminal data and social support of the participants

Regarding criminal history, overall, most inmates (52.7%) are in prison for the first time, while 47.3% are repeat offenders. As for history of recidivism, it varies between a minimum of two to seven times, with a mean recidivism of $M=2.61$, with $SD=1.20$. Regarding the legal situation of the interviewed inmates, overall, most (97.3%) had already been convicted, with 12.7% still awaiting trial while in pre-trial detention. Regarding length of stay in the prison, most inmates have been in the prison for periods between 1 and 5 years (58.2%), 25.5% have been in prison for less than 1 year, 12.7% between 6 and 10 years and 3.6% for more 10 years. The length of time to still be served varies between a minimum of half a year and 14 years, with a mean of $M=5$; $SD=3$; with 45.1% having between 2 to 5 years to complete and 37.3% between 6 and 10 years to complete. Concerning the type/category of crime, overall, 36.4% were convicted of “crimes against property”, 27.3% for “crimes against people”, 27.3% for “substance-

related crimes”, 7.3% for crimes “against life in society” and 1.8% for other crimes (see table 2).

Table 2.

Legal and criminal data

Criminal history	N	(%)
Primary	29	(52.7)
Recidivism	26	(47.3)
Recidivism	N	(%)
2 times	18	(69.2)
3 times	4	(15.4)
4 times	2	(7.7)
5 times	1	(3.8)
7 times	1	(3.8)
Legal situation	N	(%)
Preventive	7	(12.7)
Convicted	48	(87.3)
Incarceration time	N	(%)
Less than 1 year	14	(25.5)
1 – 5 years	32	(58.2)
6 – 10 years	7	(12.7)
More than 10 years	2	(3.6)
Sentence time to be completed	N	(%)
Less than 2 years	7	(13.7)
2 – 5 years	23	(45.1)
6 – 10 years	19	(37.3)
More than 10 years	2	(3.9)
Type of crime	N	(%)
Against people	15	(27.3)
Against life	4	(7.3)
Against property	20	(36.4)
Substance-related	15	(27.3)
Other	1	(1.8)

Note. Min. – Minimum; Max. – Maximum; M – Mean; SD – Standard deviation.

As for the relationship with other inmates, it is often rated as reasonable (36.4%), with 34.5% giving a good rating and 27.3% a very good rating, while 1.8% rate it poorly. Concerning relationship with prison staff, it is more often rated very good (36.4%), with 34.5% giving a good rating and 23.6% giving a reasonable rating, and 5.5% rating it poorly. Regarding the exercise of some activity in the prisons, most inmates say they practice some activity (60.0%), with 78.1% performing functional activities (cleaning, canteen or bar helper, laundry helper, etc...) and 21.9% performing personal activities (sport, gym, reading, writing).

As for the existence of family support, overall, 85.5% of inmates say they have some support from family members, while 14.5% have no support at all. The most mentioned type of family support is emotional and financial support, mentioned by 54.5% of inmates, while 23.9% mention only having financial support, 8.7% only emotional support, 8.7% other types of support and 4.3% all three types of support, simultaneously. Finally, it should be noted that most inmates who receive family support (70.2%) rate it as very good, while 17.0% rate it as good, 8.5% reasonable and 4.3% as bad. With regard to receiving visits, overall, most inmates (89.1%) say they receive visits from someone, with 10.9% not receiving any visits. Visits are reported as more frequent on weekends (36.8%), while for 26.5% it is daily, 16.3% monthly and 20.4% sporadic. As for the evaluation of visits, 76.6% consider them to be very good, 17.0% good, 4.3% reasonable and 2.1% bad. As for receiving correspondence, overall, 52.8% of inmates say they receive some correspondence from someone, while 47.2% do not receive any correspondence. With regard to making telephone calls, overall, 92.7% of inmates make calls to someone outside the prison (see Table 3).

Table 3.

Data regarding relationships and social support.

Relationship with other inmates	N	(%)
Very good	15	(27.3)
Good	19	(34.5)
Reasonable	20	(36.4)
Bad	1	(1.8)
Relationship with prison staff	n	(%)
Very good	20	(36.4)
Good	19	(34.5)
Reasonable	13	(23.6)
Bad	3	(5.5)
Performance of activity	n	(%)
No	22	(40.0)
Yes	33	(60.0)
Activity performed	n	(%)
Personal activities	7	(21.9)
Functional activities	25	(78.1)
Existence of family support	N	(%)
No	8	(14.5)
Yes	47	(85.5)
Type of family support	N	(%)
Emotional	4	(8.7)
Financial	11	(23.9)
Other	4	(8.7)
Emotional & Financial	25	(54.5)
Emotional, Financial and Other	2	(4.3)
Assessment of family support	N	(%)
Very good	33	(70.2)
Good	8	(17.0)

Reasonable	4	(8.5)
Bad	2	(4.3)
Receiving visits	n	(%)
No	6	(10.9)
Yes	49	(89.1)
Frequency of visits	n	(%)
Daily	13	(26.5)
Weekends	18	(36.8)
Monthly	8	(16.3)
Sporadically	10	(20.4)
Assessment of visits	n	(%)
Very good	36	(76.6)
Good	8	(17.0)
Reasonable	2	(4.3)
Bad	1	(2.1)
Reception of correspondence	n	(%)
No	25	(47.2)
Yes	28	(52.8)
Makes phone calls	n	(%)
No	4	(7.3)
Yes	51	(92.7)
Total	55	(100.0)

Relationship between social support, well-being and quality of life

Perceived social support. Analyzing the four dimensions of the MSPSS scale, it appears that the “Total” of the MSPSS scale varies between 2.5 and 7, presenting an mean of 5.6 and a standard deviation of 1.1 ($M=5.6$; $SD=1.1$), meaning that, on average, inmates perceive partial social support from their network of contacts. Following the dimension “social support from significant others” with a mean score of 6.2 and standard deviation of 1.1 ($M=6.2$; $SD=1.1$), the dimension “social support from family” with a mean of 5.9 and standard deviation of 1.7 ($M=5.9$; $SD=1.7$) and, finally, the dimension “social support from friends” with a mean of 4.8 and standard deviation of 1.9 ($M=4.8$; $SD=1.9$). To study the existence of differences between the four dimensions of PSS, the Friedman test (Table 4) was applied, since the distribution of SS is not normal ($p < 0.05$), in all four dimensions of the scale.

Table 4.

Comparison of dimensions of the MSPSS multidimensional scale

Dimensions	N	Min-Max	M±SD	Test of Normality	Mean of Orders	Friedman Test
MSPSS_F	55	1-7	5.9±1.7	KS=0.266; $p < 0.001$ ***	2.24 a	$\chi^2=26.699$
MSPSS_FR	55	1-7	4.8±1.9	KS=0.141; $p=0.008$ *	1.48	gl=2
MSPSS_SO	55	2-7	6.2±1.1	KS=0.231; $p < 0.001$ ***	2.28 a	$p < 0.001$
MSPSS_T	55	2.5-7	5.6±1.1	KS=0.181; $p < 0.001$ ***	2.32	

Note. Min. – Minimum; Max. – Maximum; MSPSS_F – Family; MSPSS_FR – Friends; MSPSS_SO – Significant others; MSPSS_Total; a – pairs of significantly equal means (Friedman Test)

*** $p < .001$; ** $p < .01$; * $p < .05$; ns – not significant

Applying the Friedman test ($\chi^2=26.699$; $gl=2$; $p < 0.001$ ***), since $p < 0.05$, it is concluded that levels of PSS are not the same, that is, there is a form of PSS significantly different from another form of PSS. Using the mean of orders, it is observed that PSS from “significant others” has a support level (2.28) significantly higher than the other types of PSS, significantly equal to the PSS from “family” (2.24) and higher than the PSS

from “friends” (1.48). To study the correlation between the dimensions of PSS, the Spearman correlation test was applied, since all dimensions fail to meet the assumption of normality (Table 5).

Applying the Spearman correlation test on the six pairs of correlations of the PSS dimensions (Table 5), since $p < 0.05$, there is a significant correlation between five of the six pairs of correlations of the PSS dimensions; there is no significant correlation between the family SS (MSPSS_F) and friends SS (MSPSS_FR).

Table 5.

Correlation between scores on the MSPSS dimensions

	1	2	3
1. MSPSS_F	-----		
2. MSPSS_FR	0.172 ns	-----	
3. MSPSS_SO	0.309 *	0.331 *	-----
4. MSPSS_T	0.559 ***	0.813 ***	0.555 ***

Note. Min. – Minimum; Max. – Maximum; MSPSS_F – Family; MSPSS_FR – Friends; MSPSS_SO – Significant others; MSPSS_Total; a – pairs of significantly equal means (Spearman correlation test)

*** $p < .001$; ** $p < .01$; * $p < .05$; ns – not significant

Since the Rho correlation coefficients are positive, it is proven the existence of direct or positive relationships, observed in the table, and existent in the original MSPSS scale by Zimet et al. (1988). Within the pair of correlations with the highest degree of correlation, we highlight the correlation between the dimension “friends” (MSPSS_FR) and total SS (MSPSS_T) (Rho=0.813), while the correlation between the “family” dimension (MSPSS_F) and the “friends” dimension (MSPSS_FR) is not significant (Rho=0.172); meaning that inmates who experience low SS from family have a tendency to obtain high PSS from their friends.

Subjective well-being. Observing the three dimensions of SWB, it appears that the total subjective well-being (SWB_T) varies between 1.7 and 4.05, with a mean of 2.9 and standard deviation of 0.5 ($M=2.9$; $SD=0.5$), meaning that the SWB of inmates is, on average, slightly below moderate intensity. It is followed by the “positive affect”

dimension (SWB_P), with a mean of 3.0 and standard deviation of 0.8 ($M=3.0$; $SD=0.8$), corresponding to a moderate intensity, according to the classifications of the original scale (Table 11). In turn, with regard to the intensity of “negative affect” (SWB_N), it presents a mean of 2.1 and a standard deviation of 0.9 ($M=2.1$; $SD=0.9$), corresponding to a frequency that has been rarely felt in recent weeks.

To study the existence of significant differences between the dimensions of SWB, the Wilcoxon test was applied (Table 6), since the distribution of SWB is not normal ($p<0.05$) in the dimension of “negative affect” (SWB_N).

Table 6.

Comparison of SWB dimensions

Dimensions	N	Min-Max	M±SD	Test of Normality	Mean of the Orders	Wilcoxon test
SWB_P	55	1.2-4.7	3.0±0.8	KS=0.089; p=0.200 ns	29.48	Z=-4.776
SWB_N	55	1-4.5	2.1±0.9	KS=0.129; p=0.024 *	18.80	p<0.001 ***
SWB_T	55	1.7-4.05	2.9±0.5	KS=0.088; p=0.200 ns		-----

Note. Min. – Minimum; Max. – Maximum; SWB_P – Positive affect; SWB_N – Negative affect; SWB_T – Total subjective well-being; abc –pairs of significantly equal means

*** $p<.001$; ** $p<.01$; * $p<.05$; ns – not significant

Applying the Wilcoxon test ($Z=-4,776$; $p<0.001$ ***), since $p<0.05$, it is concluded that SWB levels are not equal, or that there is a dimension of the WB scale with a frequency that is significantly different from the others. In fact, the dimension associated with “positive affect” (29.48) presents a frequency that is significantly higher than the dimension associated with “negative affect” (18.80).

To study the correlation between the dimensions of the SWB scale, Pearson’s correlation test was applied between the dimension of “positive affect” and the total dimension of well-being (SWB_Total), since they have a significantly normal distribution; as well as Spearman’s correlation test for the other correlations (Table 7).

Table 7.

Correlation between scores on the SWB dimensions

	1	2
1. SWB_P	-----	
2. SWB_N	0.172 ns	-----
3. SWB_T	0.611 ***	-0.649 ***

Note. SWB_P – Positive affect; SWB_N – Negative affect; SWB_T – Total subjective well-being

*** $p < .001$; ** $p < .01$; * $p < .05$; ns – not significant

Applying the Spearman/Pearson correlation tests on the three pairs of correlations of the SWB dimensions, since $p < 0.05$, it is concluded that there is a significant correlation between two of the three pairs of correlations of the SWB_Total dimensions; there is no significant correlation between the dimension of “positive affect” (SWB_P) and the dimension of “negative affect” (SWB_N).

Quality of life. Examining the six dimensions of QOL (Table 8), the “Total” of the QOL scale, varies between 40.4 and 90.4, presenting a mean of 68.8 and a standard deviation of 13.6 ($M=68.8$; $SD=13.6$), meaning that, on average, inmates have medium QOL. Standing out, with a higher mean score, is the “physical” dimension (QOL_PhD) with a mean of 77.9 and standard deviation of 17.2 ($M=77.9$; $SD=17.2$); followed by the lowest mean score, the “general” dimension (QOL_GD) with a mean of 59.1 and standard deviation 20.2 ($M=59.1$; $SD=20.2$).

To study the existence of significant differences between the five dimensions of QOL, the Friedman test was applied, since the distribution of QOL is not normal ($p < 0.05$) in all dimensions, except for the “environmental” dimension (QOL_ED).

Table 8.

Comparison of QOL dimensions

Dimensions	N	Min-Max	M±DSD	Test of Normality	Mean of the Orders	Friedman test
QOL_GD	55	0-100	59.1±20.2	KS=0.222; $p < 0.001$ ***	2.23 ab	

QOL_PhD	55	25-100	77.9±17.2	KS=0.144; p=0.006*	4.25	$\chi^2=85.952$
QOL_PD	55	33.3-100	76.6±16.7	KS=0.148; p=0.004*	3.87	gl=4
QOL_SD	55	16.7-91.7	59.2±18.5	KS=0.135; p=0.014*	2.21 ac	p<0.001
QOL_ED	55	21.9-90.6	60.9±17.3	KS=0.079; p=0.200 ns	2.45 bc	
QOL_T	55	40.4-90.4	68.8±13.6	KS=0.113; p=0.078 ns	-----	

Note. Min. – Minimum; Max. – Maximum; GD – General Domain; PhD – Physical Domain; PD – Psychological Domain; SD – Social Domain; ED – Environmental Domain; T – Total; abc – pairs of significantly equal means (Friedman test)

*** $p < .001$; ** $p < .01$; * $p < .05$; ns – not significant

Applying the Friedman test ($\chi^2=85.952$; $gl=4$; $p < 0.001$ ***), since $p < 0.05$, it is concluded that QOL levels are not the same or that there is a QOL level significantly different from the others. In fact, the “physical” (QOL_PhD) (4.25) and “psychological” (QOL_PD) (3.87) dimensions have significantly different QOL levels among themselves and different from other QOL dimensions; with the “general” (QOL_GD) (2.23), “social” (QOL_SD) (2.21) and “environmental” (QOL_ED) (2.45) dimensions presenting levels of QOL that are lower and significantly equal.

To study the correlation between QOL dimensions, the Spearman correlation test was applied (Table 9).

Table 9.

Correlation between the dimensions of the WHOQOL-Bref

	1	2	3	4	5
1. QOL_GD	-----				
2. QOL_PhD	0.508 ***	-----			
3. QOL_PD	0.441 **	0.601 ***	-----		
4. QOL_SD	0.168 ns	0,474 ***	0.390 **	-----	
5. QOL_ED	0.399 ***	0.517 ***	0.601 ***	0.535 ***	-----
6. QOL_T	0.611 ***	0.823 ***	0.815 ***	0.635 ***	0.825 ***

Note. QOL_GD – General dimension; QOL_PhD – Physical dimension; QOL_PD – Psychological dimension; QOL_SD – Social dimension; QOL_ED – Environmental dimension; QOL_T –

*** $p < .001$; ** $p < .01$; * $p < .05$; ns – not significant

There was a significant correlation between 14 of the 15 pairs of correlations of the QOL dimensions; there is no significant correlation between the general dimension and the social dimension. Since the Rho correlation coefficients are positive, it is proven the existence of positive relationships, existent in the original WHOQOL-Bref scale.

The relationship between perceived social support, subjective well-being and quality of life. In order to demonstrate the existence of significant correlations between the dimensions of PSS and the dimensions of SWB, Spearman correlation tests were applied (since at least one dimension does not meet the assumptions of normality), and a positive correlation is expected between PSS and positive SWB.

Table 10.

Correlation between scores on the dimensions of the MSPSS and SWB

Dimensions	SWB_P	SWB_N	SWB_T
MSPSS_F	0.030 ns	0.093 ns	-0.125 ns
MSPSS_FR	-0.067 ns	-0.123 ns	0.043 ns
MSPSS_SO	0.049 ns	-0.067 ns	0.018 ns
MSPSS_T	-0.047 ns	-0.092 ns	-0.001 ns

Note. MSPSS_F – Family; MSPSS_FR – Friends; MSPSS_SO – Significant others; MSPSS_T – Total; SWB_P – Subjective well-being of positive affect; SWB_N – Subjective well-being of negative affect; SWB_T – Total subjective well-being; ns – not significant

It is concluded that there is no significant correlation between PSS and SWB, between all pairs of dimensions of the two scales (Table 1).

In order to demonstrate the existence of significant correlations between the dimensions of the PSS and the dimensions of QOL, the Spearman correlation test was applied (since at least one dimension does not meet the assumptions of normality), expecting a positive correlation between PSS and QOL.

Table 11.

Correlation between scores on the dimensions of the MSPSS and QOL

Dimensions	QOL_GD	QOL_PhD	QOL_PD	QOL_SD	QOL_ED	QOL_T
MSPSS_F	-0.195 ns	0.242 *	0.180 ns	0.288 *	0.161 ns	0.217 ns
MSPSS_FR	-0.004 ns	0.108 ns	0.099 ns	0.299 *	0.190 ns	0.187 ns
MSPSS_SO	0.135 ns	0.363 **	0.471 ***	0.778 ***	0.537 ***	0.581 ***
MSPSS_T	0.025 ns	0,329 **	0.312 *	0.527 ***	0.381 **	0.429 **

Note. MSPSS_F – Family; MSPSS_FR – Friends; MSPSS_SO – Significant others; PSS_T – Total; QOL_GD – General Dimension; QOL_PhD – Physical Dimension; QOL_PD – Psychological Dimension; QOL_SD – Social Dimension; QOL_ED – Environmental Dimension; QOL_T – Total quality of life

*** $p < .001$; ** $p < .01$; * $p < .05$; ns – not significant

In general, the total perceived social support (MSPSS_T) is significantly correlated with all dimensions of QOL and QOL_Total (QOL_T), except for the "general" dimension (QOL_GD) of QOL. As the correlation coefficients are positive, it is possible to state that inmates with a higher level of MSPSS_T usually have a higher level of QOL; this correlation being particularly strong and high with the social dimension (Rho=0.527).

In particular, the SSP dimension of "family" (MSPSS_F) (Rho=0.288; $n=55$; $p=0.033^*$) and the PSS dimension of "friends" (MSPSS_FR) (Rho=0.299; $n=55$; $p=0.027^*$) only showed a significant correlation with the social dimension (QOL_SD) of QOL; demonstrating that MSPSS_F and MSPSS_FR, when perceived by inmates, have an impact on the social dimension of their QOL. As for the PSS from significant others (MSPSS_SO), there is a significant correlation with all dimensions of QOL, except for the "general" dimension of QOL; demonstrating that the support from all prison staff has significant importance for the physical, social, psychological and environmental dimension of the inmates' QOL.

In order to demonstrate the existence of significant correlations between the dimensions of SWB and the dimensions of QOL, the Spearman correlation test was

applied (since at least one dimension does not meet the assumptions of normality), expecting to observe a correlation between SWB and QOL (Table 12).

Table 12.

Correlation between scores on the dimensions of the SWB and QOL scale

Dimensions	QOL_GD	QOL_PhD	QOL_PD	QOL_SD	QOL_ED	QOL_T
SWB_P	0.314 *	0.106 ns	0.073 ns	0.030 ns	-0.103 ns	0.067 ns
SWB_N	-0.357 **	-0.237 ns	-0.449 **	-0.090 ns	-0.439 **	-0.439 ***
SWB_T	0.533 ***	0,242 ns	0.347 *	0.041 ns	0.226 ns	0.353 **

Note. SWB_P – Subjective well-being of positive affect; SWB_N – Subjective well-being of negative affect; SWB_T – Total subjective well-being; QOL_GD – General dimension; QOL_PhD – Physical Dimension; QOL_PD – Psychological Dimension; QOL_SD – Social Dimension; QOL_ED – Environmental Dimension; QOL_T – Total Quality of Life

*** $p < .001$; ** $p < .01$; * $p < .05$; ns – not significant

In general, the level of SWB_T is directly correlated with all dimensions of QOL, and significantly with the “general” dimension (Rho=0.533; n=55; $p < 0.001$ ***) and with the “psychological” dimension of QOL (Rho=0.347; n=55; $p = 0.010$ *) and QOL_T (Rho=0.353; n=55; $p = 0.004$ **). In particular, the dimension of “positive affect” of SWB only presents a significant correlation with the “general” dimension of QOL (Rho=0.314; n=55; $p = 0.020$ *). Conversely, the dimension of “negative affect” (SWB_N) presents negative correlations with all dimensions of QOL; and significantly with the “general” (Rho= -0.357; n=55; $p=0.007$ **), “psychological” (Rho= -0.449; n=55; $p=0.001$ **), “environmental” (Rho= -0.439; n=55; $p=0.001$ **) dimensions and QOL_T (Rho= -0.439; n=55; $p < 0.001$ ***).

Discussion

This study aimed to understand the relationship between perceived social support, subjective well-being and the quality of life among inmates. Thus, through the analysis of the results obtained, it was found that, overall, the dimensions of perceived social support and the dimensions of quality of life are related to total subjective well-being.

Regarding the social support perceived by inmates, their total score is lower than the social support perceived, on the MSPSS scale, for the general population. However, this result is in line with what was expected, since living in a prison removes freedom, and imposes rules and limitations, conditioning perceived social support, as already mentioned in Novais et al. (2010). Regarding correlations between the dimensions of the perceived social support scale, there were significant correlations between all dimensions, with the exception of the dimensions of perceived social support from “family” and “friends”, which may be explained by the fact that existing relationships may not provide a protective nature, but rather risk, that is, they may be associated with delinquent behaviors, thus emotional and family distancing occurs (Gomes, 2012; Moreira, 2007).

However, it is important to highlight inmates with greater PSS experience positive affect more frequently. The need to adapt to the new context may require individuals to have a greater capacity to reorganize individual resources to face emotional and social challenges during incarceration. The presence of the family and the maintenance of social contacts can have a protective effect in stressful situations, promoting the health and WB of individuals (Carvalho et al., 2011; Gomes et al., 2003; Novais et al., 2010). In fact, in a prison context, there are several authors who corroborate that the absence or lack of perceived family support brings negative consequences on the individual's WB, resulting in feelings of rejection, low self-esteem, loneliness and shame, which may even remain after release (Oliveira & Lima, 2013; Rocha & Silvério, 2005). Therefore, the family has a significant role in bringing inmates closer to the outside environment (Pinto & Hirdes, 2006; Ramos, 2011) and, through visits, family seems to provide inmates with positive feelings and moments of general well-being, thus mitigating the negative effects that derive from the prison routine (Dixey & Woodall, 2011; Duncan & Balbar, 2008; Monahan et al., 2011). It can also influence the decrease in misconduct behaviors within

the prison (Cochran, 2012) and inmates' adherence to skills-learning programs for the future (Brosens et al., 2014), as well as, in the future, have a predictive role in decreasing the risk of recidivism (Bales & Mears, 2008; Claire & Dixon, 2015; Duwe & Clark, 2013).

However, no correlation was found between all pairs of dimensions of the PSS scale and the SWB dimensions, which can be explained by the prison situation itself or even by bad adaptation to the prison environment, generating stress and psychological ill-being in individuals, combined with deficient SS, or a low perception of it (Cohen & McKay, 1984). Corroborating Novais et al. (2010), SS and the quality of the relationships that the individual establishes with his social support network seems to positively influence the adaptation to the prison environment, and will also be a predictor of a successful reintegration (Visher & Travis, 2003).

Nonetheless, in the context of the inmates' SS, not only the role of the family may be highlighted as important. Novais and colleagues (2010) also refer to the existence of other types of established relationships, such as the relationship with other inmates and with prison staff, who also support the inmate. Overall, a direct and significant relationship was found between the total PSS and the dimensions of QOL, with the exception of the general dimension. As previously mentioned, SS increases WB levels, consequently, improving QOL levels.

With regard to the SWB scale, the evaluation of the "positive affect" dimension is predominant over the "negative affect" dimension, a profile identical to the results of Nogueira (2015), with the present study obtaining a total of subjective well-being slightly superior to that of the study of the mentioned author, with a direct and significant influence on general QOL. These results can be explained by the fact that positive emotions are present in all circumstances and enable the individual to search for

homeostasis and, consequently, adapt to the situation, to what Diener (1996) called hedonic scaling. In the present study, inmates have a low level of “negative affect”, which may be related to some difficulty in describing and expressing emotions, or even hiding them in order not to expose their weaknesses (Rijo et al., 2007). On the other hand, it may be justified by the fact that, although they are inmates, they perceive SS, consequently increasing positive feelings (Arriola et al., 2015).

Most of the study sample has an activity within the prison. The studies by Kaap-Deeder and colleagues (2017), and Laan and Eichelsheim (2013) report that, in a prison context, individuals with some autonomy over their lives and with routine activities generally perceive better levels of SWB, and that this variable is also associated with individuals’ personal growth (Fredrickson, 2001; Fredrickson & Losada, 2005), a better perception of QOL, considering it a way to reduce recidivism (Harreveld et al., 2007).

Regarding the correlation between total subjective well-being and total quality of life, a significant and direct correlation was found, meeting expectations, since higher levels of WB are generally associated with higher levels of QOL. As for the correlation between total subjective well-being and the dimensions of QOL, no significant correlations were found in the “physical”, “social” and “environmental” dimensions; since the effect of incarceration removes almost all social life from inmates and all access to a free environment that exists prior to incarceration, restricting social relations, visits, recess, meals, activities and courses and contact with prison staff. Normally, SWB directly assists QOL, and this relationship between the total dimension of SWB and the general and psychological dimensions of QOL has been proven.

Regarding QOL, the values found in the sample show better QOL in the “physical” and “psychological” dimension and better levels in all dimensions of QOL than in the study by Varela (2018), which may be explained by the fact that the sentence

time to still be completed is less than in the author's sample, and inmates find themselves with an already definitive legal situation, that is, convicted, corroborating the study by Mestre (2000). The decrease in QOL among inmates is expected and seems to have a direct impact on their health, especially when the deprivation of liberty is prolonged (Massoglia, 2008). However, the characteristics of the sample in the present study may have positively influenced QOL, as they have a reasonable relationship with other inmates and a very good relationship with prison staff. There are studies that confirm that the positive attitudes of prison staff towards inmates and the use, or not, of authority over them (Crewe et al., 2014) have an influence on the behavior and determination of QOL in inmates (Crewe et al., 2011). Thus, the provision of SS by prison staff may positively influence adaptation (Mesko & Hacin, 2018).

With regard to the correlation between the dimensions of the WHOQOL-Bref, direct and significant correlations were found between all dimensions, with the exception of the correlation between the "social" dimension and the "general" dimension, which can be explained by the rules, limitations, obligations of the prison, which condition social relationships, regardless of the physical or general capacity of the inmate. Dhami, Ayton and Loewenstein (2007) emphasize that time and QOL, prior to incarceration, affect the inmate's social contacts with family and friends.

In sum, in the prison context, the need for health promotion programs seems to be unequivocal, in order to dynamize the daily life in the prison and, above all, to promote interactions with all agents (inmates, family, prison staff) for better adaptation, and in order to reduce the negative impact that incarceration can have on the individual and on the life dynamics of their families (Brosens et al., 2014; Naser & Visser, 2006; Woodall et al., 2009; Woods et al., 2013). Besides, these programs could contribute to prevent recidivism.

Conclusions

The objectives of this study were fulfilled, thus it was possible to understand and characterize the level of total perceived social support, the level of total subjective well-being and the level of total quality of life, with the respective dimensions of each scale, as well as with the sociodemographic variables established.

However, throughout the study some limitations were recognized, namely the sample. Although it proved to be sufficient for the present study, sample size could have been higher and participants collection could be from prisons with other characteristics, for example, with a high degree of complexity, another type of prison experience, or including female inmates. Moreover, during the data collection phase, some difficulty was noted in the completion of questionnaires by some inmates. When help was requested, the answers may have been somewhat biased, in the sense that they are under some effect of social desirability.

It should be noted that the evaluation of the inmates was conducted in a single moment, which may be a limitation for the study. The results of this research lead us to reflect on some issues, namely the contextual characteristics of the situation of incarceration, and the environment and the relationships established within the prison may be facilitators for the promotion of SWB and, consequently, better QOL levels. The WHO argues that prisons should be health promoters. In fact, health promotion, in prison, could be the way to provide a more positive experience of deprivation of liberty, mitigating the harmful consequences that this has for the individual and family, and contributing to the reduction of criminal recidivism, thus fulfilling the purpose of resocialization.

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