



Research Article

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A Comparison of Psychological Capital, Social Capital, Mental Health and Health Literacy among the Mothers of Intellectually Disabled Children with the Mothers of Normal Children

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ABSTRACT

The goal of this research is to compare psychological capital, social capital, mental health and health literacy among the mothers of children with mental disabilities and mothers of normal children. The study population is consisted of all the mothers of children with intellectual disabilities and mothers of normal children in Urmia in 2015 that among them, 200 mothers are selected with random sampling, by using Morgan table. The research method is causal – comparative.

Research tools are Luthans Psychological Capital Questionnaire (2007), Delaviz Social capital questionnaire (2005), General Health Questionnaire (GHQ-28) and adult functional health literacy questionnaire (TOFHLLA) (2006). Data are analyzed using statistical software Spss and also descriptive statistics, and MANOVA was used to determine the difference between variables Multivariate analysis of variance.

The results have shown that there is a significant difference in the mean components of psychological capital of Urmia among the two groups of mothers of intellectually disabled and normal children, ($p < 0.01$). And also, between components of social capital of two groups of mothers ($p < 0.01$). Also, there is a difference between the mental health of mothers of intellectually disabled and normal children ($p < 0.05$). But there is no difference between the average health literacy test scores of mothers of disabled and normal children ($p < 0.05$).

In general, the results show that there is a significant difference among the components of psychological capital and social capital components and mental health, in both of the groups of mothers of the disabled and normal children in Urmia. In comparison with health literacy, there is no difference between mothers of the disabled and normal children.

Keywords: *psychological capital, social capital, mental health, health literacy*

INTRODUCTION

Health literacy is the degree in which each person has the capacity to obtain, process and understand the primary health information and make an appropriate decision that includes: the ability to understand instructions on prescription drug bottles, medical educational brochures, consent forms, the ability to use complex medical systems [7], reading, listening and analysis, decision-making and the ability to apply these skills in health situations that do not necessarily come back years of schooling or public reading ability [21]. The definition of WHO of "health

literacy" is as "cognitive and social skills and cognitive ability to understand and use information in ways to promote and maintain good health" [8].

Clearly the issue of health literacy is expressed in the perspective plan of the health system of Islamic Republic of Iran in 1404. Also the Islamic Republic of Iran, in 1404, is the able-bodied society, in the vision of twenty years. People in this community of health literacy (the ability to access information, analysis and decision-making power in the health field) will have an appropriate level of social capital. The goal of Healthy People 2010 express that health literacy increasingly helps people assess their health information [7].

Today, mental health not only means the loss of mental illness, but also it means the ability to create harmony between values, interests, aspirations and problems and the ability to correct exploitation of opportunities on time, as well. Mental health is associated with a desire to grow, flourish and reflect the ability to love, create and feel merit. According to the World Health Organization, mental health is the ability to solve problems and contradictions of life, establish effective relationships with others and adapt or modify the living environment in a manner that provides individual growth [4]. Hence, mental health is important for many individuals and organizations, and its disorders predispose to psychiatric and physical disorders [15]. That's why researchers are trying to find ways to enhance mental health. Including the research has noted that the role of positive structures such as hope and optimism in mental health and the final result of the use of training programs based on positive initiatives to promote mental health as well as increasing health literacy have been advised [4,19].

Psychological capital is a set of positive attributes and capabilities of individuals and organizations like a powerful resource that can involve the development and promotion of the individual and organization. Hope, optimism, self-efficacy and resilience are the components of psychological capital [1].

Hope, is a motivational state and has three components, including functionality, design and purpose [5]. Optimism is an internal document about positive events that are relatively constant and universal. Self-efficacy means, ensure you have the needed abilities to achieve success and a belief in the ability to overcome challenging assignments and resiliency is a positive mental capacity to return and leaping from tragedies and positive change in the direction of progress have been defined which prepares individuals to take responsibility [10].

Optimism performs programs in order to distinguish real optimism and unrealistic optimism and increase positive attributions. Self efficacy through programs such as feedback, positive reinforcement and strong succession have provided the perfect backdrop for business success through feedback, positive reinforcement, learning through model-making and strong succession increase. Also, measures have taken place to boost endurance in particular through a tough training and a belief in the ability to influence outcomes of events and opportunities for growth and promotion [10]. It must be said health literacy is an essential foundation for modern health and lives of citizens. Health literacy is a critical component of social capital which should be considered as a matter of policy, not only in the health sector but in all other sectors [18].

In this regard, some social psychologists, such as Lefcourt (2002), argue that the explanation of psychological Capital will remain incomplete without any regard to the role of social factors; Because in many interpersonal situations, personal perception of the imposed social networking imposed, selected and built can overshadow a person's adaptive behavior and even thwart the role and impact of individual factors lead to mental well-being.

Hence, Decker (2001), in his theoretical model, striking the role of social factors, especially social capital matters, states that social capital can facilitate or moderate the influence of psychological well-being. Lynch & Kaplan (2007) have introduced social capital as a form of accumulation and networks, social solidarity, social commitment and thus creating a kind of self-esteem and well-being of the people.

Social capital is a hybrid concept that describes an amount or level of certain norms and networks in the community and timeframe. In this regard, the results of Lee research (2005) as alcohol and stress domination and the effects of social support on health and well-being have shown that there is a significant relationship between the perceived social support from friends and family in operations, emotional intelligence and depression status, alcohol

consumption and physical and mental health. In a research Harahan (2004) has shown that problems such as poverty, failure in school, living in a poor physical environment, high levels of insecurity in a society and issues such as negative life events of social factors that have an impact on health and well-being.

So, social capital and its role in health can reduce stressors in life and reduce risk factors, and can also reduce the negative life events such as losing job and the compatibility of the people in their lives. On the other hand, research shows that people who are socially isolated have less mental health conversely, the greater the social cohesion in society the more the healthy society. Although the close relations between these two factors (psychological well-being and psychological capital) have been widely recognized in the research literature, Waters and Moore (2002) admit the ways in which the components of psychological capital on mental health and health literacy are not so clear.

According to the subjects mentioned, this study compares the psychological capital, social capital, mental health and health literacy among mothers of children with mental disabilities and normal children's mothers.

2. Research Methodology

Since this study is to compare psychological capital, social capital, mental health and health literacy of mothers of children with mental disabilities and mothers of normal children, the causal-comparative method is used. Therefore, the methodology of this study is causal-comparative. The population in this study consists of all mothers with mentally disabled children and mothers of normal children in Urmia in 2015. In this study, we have used random available sampling. In randomly selected subjects, there is an equal chance of being selected. By using Morgan, the sample size is 200 patients (100 mothers of children with ID and 100 mothers of normal children) that mothers of children with ID are selected from Arse Talash and Rahmat schools and mothers of normal children are from Ostad Shahriar and Danesh schools. Sampling mothers of children with intellectual disability has been available random by draw and sampling mothers of normal children has been random cluster.

3. Data Collection tools

Psychological capital questionnaire(PCQ): To measure psychological capital, we have used Luthans psychological capital questionnaire. The questionnaire is used to standardize values that range for structures hope, resiliency, optimism and self-efficacy. And the validity and reliability of the subscales have also been confirmed. The questionnaire consists of 24 questions of 4 subscales where each subscale consists of 6 items, subject response to any items and 6 degrees (strongly disagree to strongly agree), Likert-type.

Delaviz Social Capital Scale (DSCS): To measure social capital, we have used Delaviz social capital questionnaire (2005). The questionnaire is normalized to measure social capital among the students of nationwide, Medical Sciences, Tabriz, Azad and PNU. The questionnaire contains 27 questions and has 4 subscales (trust, collaboration, participation in local community relations and social networks) and scoring method is based on the whole five-point Likert. The score of 19, 18 and 20 in reverse and other questions in order to fully agree (4) and strongly disagree (0) grading and the total score of the test is 108.

General Health Questionnaire (GHQ-28): General Health Questionnaire has been used to assess mental health status. This tool is one of the most well-known screening tools in Psychiatry and Psychological evaluations that had a big impact on the progress of research [8]. 28 questions asked by Goldberg and Hillier made from the original form which includes 4 subscales of 7 items somatic symptoms, anxiety, social dysfunction and depression (Goldberg & Hillier, 1979).

Health literacy scale: To assess health literacy we have used the test of functional health literacy in adults or TOFHLA (2006). This questionnaire is one of the most important and valid questionnaires of measuring health literacy worldwide and has so far been validated and translated into several languages.

4. Results

Hypothesis 1: There is a difference in psychological capital between mothers of children with ID and mothers of normal children of Urmia.

Table 1: Descriptive Index scores Kolmogorov-Smirnov components of psychological capital

| Significant level | <i>k-sz</i> | The observed differences in relative abundance | | | standard deviation | <i>mean</i> | Component |
|-------------------|-------------|------------------------------------------------|----------|----------|--------------------|-------------|------------|
| | | negative | positive | Absolute | | | |
| 0.11 | 0.190 | 0.19 | 0.21 | 0.17 | 32.9 | 28 | Hope |
| 0.23 | 0.176 | 0.18 | 0.12 | 0.16 | 18.58 | 30 | Resiliency |
| 0.15 | 0.221 | 0.13 | 0.20 | 0.20 | 23.84 | 26 | Optimism |
| 0.15 | 0.146 | 0.13 | 0.18 | 0.15 | 28.48 | 25 | Efficacy |

As we can see in Table 1, Kolmogorov-Smirnov test results ($p < 0.05$) show normal distribution component scores of psychological capital questionnaire.

Table 2: Results Bartlett's test of sphericity of solidarity dependent variables

| meaningful | freedom degree | Chi square approximate | Probability |
|------------|----------------|------------------------|-------------|
| 0.001 | 9 | 752 | 0.0001 |

As shown in Table (2), we can see the statistical significance of enough correlation between the dependent variables. (752 Approximate running χ^2 with $p < 0.001$)

Table 3: Analysis of variance in test groups of psychological capital

| <i>P</i> | <i>F</i> | Root Mean | <i>df</i> | Sum of squares <i>III</i> | <i>component</i> |
|----------|----------|-----------|-----------|------------------------------|------------------|
| 0.001 | 218 | 9037 | 1 | 456 | Hope |
| 0.006 | 10 | 400 | 1 | 180 | Resiliency |
| 0.004 | 1.3 | 7.9 | 1 | 564.48 | Optimism |
| 0.017 | 6.7 | 616 | 1 | 36.55 | Efficacy |

As in Table 3, we can see the components of psychological capital between the two groups of mothers of children with ID and ordinary Urmia, where there is a significant difference ($P < 0.001$, $f(4,195) = 1179.69$, $Wilks = 0.140$). Therefore, the null hypothesis is rejected. It is concluded that there is a significant difference between the component groups of mothers of children with ID and normal psychological capital city of Urmia. So, results of Table 3 show the average of all the components of psychological capital (hope, resiliency, optimism and self-efficacy) groups of mothers of children with ID and ordinary significant difference level ($P < 0.01$).

Hypothesis 2: In social capital there is a difference between the mothers of children with mental disabilities and mothers of normal children.

Table 4: Descriptive indicators of Kolmogorov-Smirnov test scores landholding

| Sig | k-sz | observed differences in relative abundance | | | standard deviation | mean | Component |
|------|-------|--------------------------------------------|----------|----------|--------------------|-----------|---------------------------------------|
| | | negative | positive | absolute | | | |
| 0.21 | 0.180 | 0.29 | 0.25 | 0.27 | 4.1 | 25 | Trust |
| 0.63 | 0.196 | 0.38 | 0.13 | 0.36 | 3.6 | 21 | Collaboration |
| 0.55 | 0.291 | 0.17 | 0.12 | 0.21 | 5.7 | 18 | Community involvement in neighborhood |
| 0.65 | 0.346 | 0.14 | 0.18 | 0.15 | 9.4 | 19 | Relations in social networks |

As in Table 4, Kolmogorov-Smirnov test results have shown that normal distribution of scores is a component of social capital questionnaire. ($p < 0.05$)

Table 5: Bartlett's test of sphericity Results of solidarity dependent variables

| sig | df | χ^2 | Probability |
|-------|----|----------|-------------|
| 0.001 | 9 | 321 | 0.002 |

As in Table 5, the statistical significance of enough correlation between the dependent variables. (321 Approximate running Xi with $p < 0.001$)

Table (6): 2 groups analysis of variance of psychological capital

| P | F | Root Mean | df | Sum of squares III | Variables |
|-------|-----|-----------|----|-----------------------|---------------------------------------|
| 0.001 | 318 | 1037 | 1 | 656 | Trust |
| 0.006 | 260 | 2500 | 1 | 380 | Collaboration |
| 0.004 | 258 | 65 | 1 | 687 | Community involvement in neighborhood |
| 0.017 | 67 | 312 | 1 | 365 | social networks Relations |

As shown in Table (6), significant difference in the components of social capital between mothers of children with mental disabilities. ($P < 0.01$, $f(4,195) = 1279/09$, $Wilks = 1/040$). Therefore, the null hypothesis is rejected. We can

conclude that due to social capital components flowing, there is a significant difference between the two groups of mothers of children with ID and in normal. Results of Table (6) show the average of all the components of social psychological capital (trust, collaboration, participation in neighborhood relations and social networks) groups of mothers of children with ID and ordinary in Urmia at the significance level ($P < 0.01$) so, there is a significant difference.

Hypothesis 3: There is a difference between the mental health of mothers of children with mental disabilities and mothers of normal children.

Table (7): Bartlett's sphericity test results on the correlation of dependent variables

| meaningful | Degrees of freedom | Chi approx. | Probability |
|------------|--------------------|-------------|-------------|
| 0.0001 | 9 | 423 | 0.0001 |

As in Table (7), the statistical significance of correlation between the dependent variables is enough. (423 Approximate running Xi with $p < 0.0001$)

Table (8): Analysis of variance in test groups of public health (mental)

| <i>P</i> | <i>F</i> | Root Mean | <i>df</i> | Sum of squares <i>III</i> | Dimension |
|----------|----------|-----------|-----------|------------------------------|----------------------|
| 0.04 | 0.107 | 0.54 | 1 | 0.545 | Physical functioning |
| 0.03 | 1.73 | 1.8 | 1 | 1.88 | Social function |
| 0.02 | 2.04 | 6.7 | 1 | 6.7 | Anxiety |
| 0.01 | 0.053 | 0.081 | 1 | 0.081 | Depression |

As shown in Table (8), It is observed that there is a significant difference in increasing mental health between mothers mentally disabled and normal children in Urmia ($p < 0.05$, $f = (4,195)$, Wilks=115). Therefore, the null hypothesis is rejected. We can conclude that there is a difference between the psychological health of mothers of intellectually disabled and normal children in Urmia. As the results of Table (8) show there is a significant difference between the compared average of all mental health of women and men exists at significant levels ($p < 0.05$).

Hypothesis 4: there is a significant difference between the mental health literacy of mothers of children with disabilities and mothers of normal children.

Table (9): descriptive data and Z test results

| Kolmogorov-Smirnov test results | | Descriptive results | | | |
|---------------------------------|------------------|---------------------|----------|-------|---------------------------------|
| The significance level | k-s _z | Standard deviation | Variance | mean | group |
| 0.193 | 0.13 | 10.87 | 118.28 | 57.56 | Mothers of Exceptional Children |
| 0.166 | 0.17 | 10.69 | 114.43 | 54.60 | Mothers of normal children |
| Z= 1.6 | sig= 1.96 | | | | |

As the results of Table (9) show, the level of health literacy among mothers of children with exceptional and routine considerations ($z=1.6$ in $p<0.05$), there exist no significant difference. So, the mean level z (0.05) is less than the critical value, 96.1. So, with 95 percent, the null hypothesis is confirmed and we conclude that there is no difference between the average scores of emergency and routine health literacy of mothers of exceptional children.

5. Discussion and conclusion

Psychological capital, a function of social capital and social relationship, determines the quality and quantity of interactions in social capital. On the other hand, social relations have an effect on the level of psychological capital. Thus, changes in the quantity and quality of social relationships influence a person in performance. Studies also show that the fluctuations and changes in psychological capital for private and public levels are consistent with changes in the social capital.

There is a difference between the psychological capital of mothers of children with mental disabilities and mothers of normal children. This is consistent with the findings of the investigations [2,10]. In order to justify these findings, we can consider life satisfaction as an important factor to help people. Psychological capital is a powerful force for people to deal successfully and easily with stressful situations known at the time of difficulty for facility. Also, the role of psychological capital through a mediator between life stressors and mental and physical problems as well as strengthening the understanding of people reduces tension, and increases people's quality of life and psychological capital components [1].

So, the promotion of psychological capital in the society is considered to be the capability index of the social system. This ability to practice by examining the lives of the population is taken into account. Thus, policymaking and planning should be based on tools and facilities to improve the quality of the lives of individuals, create a balance and integration in society and with an advertising system strengthen their social relations and correlations.

There is a difference between the social capital of mothers of children with ID and mothers of normal children. The findings of this study are consistent with the results Lahsaie Zadeh and Moradi (2007), Riahi (2007) and Sarasino (2010); they show that social capital and its components have a positive and significant relationship with the psychological capital. This means that people in the social life and more social networks also have a higher life satisfaction. The results show that the health of citizens in individual and public levels is consistent with the variation in the social capital. To put it more clearly, high levels of social capital are looking to increase their individual and public health, increasing life expectancy, more positive health behaviors, and health and life satisfaction and psychological well-being. The researchers also show that people with high social capital have fewer interpersonal problems, can stand against stressful life events, and possess more resistance and better health literacy and mental health as well.

There is a difference between the mental health of mothers of children with mental disabilities and mothers of normal children. This hypothesis can explain the results of this study with the results of Mehrabi Zadeh et al. (2001) have shown that there is a significant difference between the mental health of parents with intellectual disability and parents of normal children. Also, the results of Shariati and Davarmanesh (2011) are consistent, which show that a mentally retarded child severely affect the mental health of parents and increase physical and mental stress of parents, especially mothers, and reduce their resistance against the disease, and as a result the amount of their illness is risen. Meanwhile, Lajevardi (2012) show that depression amount of mothers of educable mentally retarded children, and mothers of normal children show that depression in mothers of children with intellectual disabilities is significantly higher than mothers of normal children. The study results are also consistent with Khajehpour (2008) who revealed neurotic reactions of mothers of disabled children more than mothers of normal children and the existence of such a situation in the family, in addition to the emotional and psychological problems for the family, especially the mother, the family is experiencing economic and social problems. In addition, most mothers' reactions are depression, anxiety and aggression. Ardeshir Shiri et al. (2013) in a study entitled as *Investigate the Relationship between Self-Regulation and Mental Health of Ilam University* have shown that there is a significant positive relationship between self regulation and mental health. The results also show that there is a significant positive relationship in self-regulation and dimensions of health (mental, social, physical). Yarahmadi (2008) researches on the relationship between stress and physical illness, mental and general health of male teachers in the city of Ahvaz with the effect of moderating variables of social support and locus of payments support. In this study, the population of male teachers working in primary and secondary education in the city of Ahvaz are four areas 200 of which are selected by multistage random. The results show that there is a positive correlation between stressors and physical and mental illnesses and a negative correlation between stressors and general health. The results of Narimani et al. (2005) show that there are differences between the four groups of mothers of children with mental retardation, blind, deaf and intact mental disorders, depression, anxiety, psychosis, phobia. With regard to depression, anxiety, psychosis, and the whole test, also the aggression variable is at a meaningful level. Phobia is an illness at a meaningful level like obsession, compulsion, interpersonal sensitivity, and paranoid ideation. There is no significant difference between groups. Using post hoc test shows that there is a significant difference in depression among mothers of deaf children with mothers of educable mentally retarded children, there is a significant difference between mothers of normal children with mothers of educable mentally retarded children, and between mothers of normal children with mothers of blind children. Totally, respectively, the mothers of educable mentally retarded children have a depression higher than the average. And the mothers of children who are blind, deaf and normal are next in rank. There is a significant difference regarding anxiety among mothers with deaf children with mothers of educable mentally retarded children, and between mothers of normal children with mothers of educable mentally retarded children. Totally, educable mentally retarded children of mothers with higher anxiety scores are the mothers of children who are blind, deaf and secondly are normal. In terms of aggression, there is a significant difference between the mothers of blind children with mothers of educable mentally retarded children; among mothers of children with mothers of deaf blind children; and between mothers of normal children with mothers of deaf. In total, mothers of children with hearing loss have an aggression higher than the average. There is a significant difference concerning the common phobia among mothers of children with mothers of educable mentally retarded children, between mothers of normal children with mothers of blind children, and between mothers of normal children with mothers of deaf children. There is a significant difference between mothers of normal children with mothers of deaf children. Totally, mothers of children with hearing loss have Phobia higher than the average. And mothers of blind children, educable mentally retarded and normally are next in rank. There is a significant difference in terms of the psychosis among mothers of normal children with mothers of educable mentally retarded children.

There is a significant difference between mothers of normal children with mothers of blind and hearing loss children. In total, mothers of children with hearing loss have Phobia higher than the average. And mothers of educable mentally retarded children, blind and normal are next in rank. There is a meaningful difference concerning the mean of the whole test among mothers of normal children with mothers of educable mentally retarded children. There is a significant difference between mothers of normal children with mothers of hearing loss children. In total, the mothers of educable mentally retarded children have a mental disorder higher than the average and then mothers with children hearing loss, blind and normal are next in rank. In terms of the obsession, compulsion, interpersonal

sensitivity and paranoid ideation, there is no significant difference between the groups that are consistent with the results of this research.

There is a difference between the mental health literacy of mothers of children with disabilities and mothers of normal children. This hypothesis can explain that the results of this study and the results of Meshki and et al. (2008) are consistent. Their results show that the t test before the implementation of the program reveal that there is not a significant difference in any of the variables between the two groups after the intervention, but not with changes in administrative work. The program was designed, differences of inner beliefs, luck and influential people, health education and in particular mental health between the two groups got significant and evident. In all cases, the variables in the experimental group was better than the control group. The paired t-test show significant difference between variables in order to improve the situation before and after the intervention. While, in the control group, the mean difference of mental health, belief in luck and health literacy are so significant. After intervention, the mean decrease and condition of the control group subjects; inadequate in terms of these variables have been shrinking. The odds ratio test, show the risk of mental health promotion in the experimental group, after the implementation of the program, according to the numerical value; criterion for measuring the level of mental health is 13 times higher; so, after the intervention and after the waiting time, 37% of the control group and the test health have a good mental health. However, the earlier the intervention, 42% of the intervention group and 58% in the intervention and control group students, have a good mental health. This situation demonstrates the effectiveness of the program after the intervention. As well as Tehrani and Banihashemi (2007) show in their results that those with low health literacy use more emergency services, more admitted to hospitals, are compatible with the drugs and benefit less than preventive services. Also the research results of Feinstein, Donald and Jordan (2012) show that in connection with the relationship between health literacy and depression with job satisfaction and the relationship between control centers on a sample of 32 individuals of secondary school teachers and 17 teachers of students with emotional disorders, showed the negative correlation between job satisfaction and depression and the positive correlation between health literacy and job satisfaction. Control centers (internal and external) have no significant effect on depression and linking both depression to an extent that is consistent with the survey results.

According to the findings, the managers and officials are suggested to involve:

1. According to the first hypothesis, which states that there is a significant difference between the psychological capital of mothers of children with mental disabilities and mothers of normal children of Urmia; it is suggested that by holding workshops for increasing mothers' psychological capital and growth factors that influence resilience, optimism, hope and efficacy of this group, play an important role in the growth and dynamism of society improvement.
2. According to the second hypothesis, which states that there is a significant difference between the social capital of mothers of children with mental disabilities and mothers of normal children of Urmia, it is suggested holding workshops by mothers to increase social capital and growth factors that influence trust, collaboration, community participation, and social networking relationships, since it plays an important role in the growth and dynamism of society improvement.
3. According to the third hypothesis, which states that there is a significant difference between the mental health of mothers of children with mental disabilities and mothers of normal children in Urmia, it is suggested that by improving mental health of mothers, their anxiety, depression and social dysfunction should be reduced and a step in the growth and dynamics of society should be taken.
4. According to the fourth hypothesis, which states that there is no significant difference between the mental health literacy of mothers of children with disabilities and mothers of normal children in Urmia, it is recommended that educational programs increase the ability to read written information about the fields of health, as well as the ability to understand written and oral information from doctor, nurse offered to the person and the ability to act according to the instructions on the applications in the pharmaceutical and health care of mothers and the entire population.

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