

## The role of social support in the psychological illness of women\*

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**Objective:** to analyze the relationship between perception of social support and emotional and physical symptoms associated with psychiatric conditions among women. **Method:** a cross-sectional, quantitative study was carried out with a randomized random sample of 141 women attended at a Family Health Unit of the city of Ribeirão Preto/ SP. A sociodemographic questionnaire, the Social Support Questionnaire and the Self-Report Questionnaire were used. **Results:** there was no association between sociodemographic characteristics and mental disorder, but between aspects such as low income and schooling. The exercise of professions culturally considered as of low prestige gave rise to some reflections related to gender inequality. There was a significant difference in the satisfaction scores between the women who reported or not the symptoms of tiredness and sadness and the number of supporters among those who reported or not the symptom of fatigue. Spouses and children were the most mentioned supporters, and having mental disorder was significantly associated with having no friends in the support network. **Conclusion:** issues related to gender equity and satisfaction with social support are important aspects of care. For the promotion of mental health, efforts must be made to make women feel more connected and supported by the supporters available in their social environment.

**Descriptors:** Social Support; Primary Health Care; Health Promotion; Women; Mental Health; Mental Disorders.

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## Introduction

Social support has been described as the available aid in the physical, psychological, material needs and the encouragement provided by individuals who make up the contact network, that is, family members, friends, neighbors, co-workers and others<sup>(1-2)</sup>. The social support network, in turn, consists of the set of persons or institutions that the individual realizes that he/she can trust or count for the provision of care, love and values<sup>(3)</sup>.

Studies have been developed on the effects of social support on people's health, associating it with different health outcomes<sup>(1-2,4-5)</sup>. Such a construct has been related to better abstinence rates and decreased use of drugs, as well as to the abandonment of behaviors harmful to health<sup>(6)</sup>.

Social support also influences how the individual evaluates and deals with stress, acting as a buffering of its negative consequences<sup>(2)</sup>.

The term "perception of social support" refers to whom the individual considers as a potential source of help for different needs. This perception is influenced both by the existence, in fact, of the sources of support, by the availability of the supporters, as well as by socioeconomic, psychological, cultural and professional aspects and age group, health conditions, and gender<sup>(7)</sup>.

Regarding gender, previous studies have pointed out that women are more likely to seek, receive, and benefit from social support<sup>(8-9)</sup>. However, they have also pointed out that the responsibilities culturally attributed to women, such as the care of children, of the sick ones, of the elderly, and household chores often create situations in which they need to resort greatly to their support networks<sup>(8-9)</sup>. Thus, both in the scope of research and care, the perception of social support can be considered an indicator of mental health, especially among women.

Studies indicate that better social support rates are inversely related to mental disorders<sup>(8,10)</sup>. That is, social support may act as a protective factor for mental health, mitigating the symptoms related to these disorders.

Research on social support and psychic symptoms in women has been developed with pregnant women, women who have recently given birth, or who have a specific health condition, such as cancer<sup>(5,10-12)</sup>. In view of the above, the following research question is proposed: Is there a relationship between social support and psychic illness among women in the general population? Therefore, the objective of the present study was to analyze the relationship between the perception of social support and the emotional and physical symptoms associated with psychiatric conditions among women of the general population.

## Method

This is a cross-sectional quantitative study carried out with women attended at a Family Health Unit in the city of Ribeirão Preto. The coverage region of this unit includes disadvantaged areas with respect to health and social outcomes due to factors such as poverty, low schooling, lack of sanitation, and high levels of violence. The service offers care in the areas of childcare, prenatal, gynecology, nursing and home care, family planning, and preventive actions in the community, with strong performance of community health workers.

The total number of women registered in this unit is 786, and 441 were in the age group between 18 and 65 years. The study participants were women of this age group, who were treated at this primary health care service. The only exclusion criterion adopted was having a clinical condition that impaired participation in the study (auditory, visual or speech impairment).

For the sample calculation, the formula for population with known size was used, proposed in literature<sup>(13)</sup>:

$$n = \frac{p(1-p)Z^2N}{\epsilon^2(N-1) + Z^2p(1-p)}$$

The parameters used for the calculation were 95% confidence, 10% sample error and 44% estimated prevalence, considering a previous study on the prevalence of suspected cases of mental disorder among primary care women<sup>(14)</sup>. The estimated sample was 79 participants. A total of 220 women were invited and 141 accepted to participate, as shown in Figure 1. The main reason for refusal was the unavailability of time to respond to the questionnaire.

The randomization was done from a list with all the addresses of the families registered that had at least one woman. One woman from each randomly selected residence was invited face-to-face or by telephone to participate in the study. The data collection was carried out by a PhD student in psychology, a nurse with a master's level and two health workers from the same service who were trained for this data collection, which occurred during home visits or at the health unit, according to the preference of women.

The instruments of data collection were a sociodemographic questionnaire, the Social Support Questionnaire (SSQ) and the Self-Report Questionnaire (SRQ 20).

The SSQ, validated in Brazil, is composed of 27 questions and is divided into two parts. In the first one, the participant is asked to indicate the names of supporters for

different situations, and can list from none to nine for each situation. Such information compose the social support score related to the number of supporters (SSQ-N). In the second part, the respondent reports his/her satisfaction with the support received, using a Likert scale, ranging from "very satisfied" (6) to "very dissatisfied" (1), composing the satisfaction score with the social support (SSQ-S)<sup>(15)</sup>.

The SRQ 20 was developed by the World Health Organization to assess symptoms of mental disorders in developing countries. The instrument is derived from four others: General Health Questionnaire (GHQ-60), Present State Examination (PSE), Post-Graduate Institute Health Questionnaire N 2 (PGI) and Patient Symptom Self-Report (PASSRo)<sup>(16-17)</sup>.

The original version has 24 items, in which the first 20 items evaluate non-psychotic disorders and the other four items, psychotic disorders. In the Brazilian version, as the study in which it was adapted was carried out in a Primary Health Care context, only the first 20 items are used<sup>(16-17)</sup>. The questionnaire has 20 "yes" or "no" questions about emotional and physical symptoms associated with psychiatric conditions. The sum of positive responses composes the final score (Score SRQ). Mental disorder cases are suspected when there are eight or more positive responses<sup>(16)</sup>.

The analyzes were carried out by a statistician, using R program, version 3.3.0. In the exploratory

analysis, Pearson's Chi-square test or Fisher's exact test was used, considering the sociodemographic variables, the composition of the support network and the suspected cases of mental disorder. In relation to the variables symptoms and social support scores, the Mann Whitney test was used. To analyze the correlation between social support scores and SRQ scores, we used the Pearson correlation test.

The results of the exploratory analysis were the guiding factors for the delineation of a regression model. Thus, in the logistic regression analysis, the suspected mental disorder (score equal to or above eight points) was considered a dependent variable, classified as yes or no. The independent variables were self-reported color (white or yellow/black or brown), having children (yes/no), income (up to two minimum wages/above two minimum wages), exercising paid activity (yes/no), number of supporters (up to six/seven or more), satisfaction with support (yes/no), and presence of supportive friends (yes/no). From the adjusted regression model, the odds ratio and the corresponding confidence interval were calculated. The level of significance used in the analyzes was 5% ( $\alpha = 0.05$ ).

In order to carry out the study, all the ethical aspects provided for in Resolution 466/2012 of the National Health Council were met (Protocol CAAE-51267015.0.0000.5393).

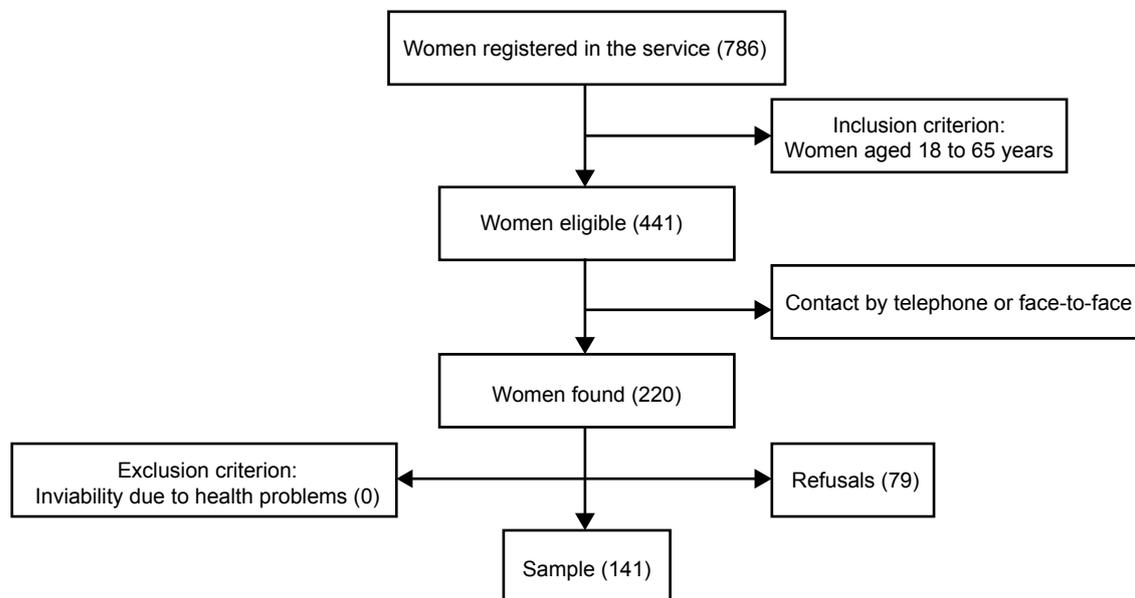


Figure 1 - Diagram of constitution of the sample

## Results

Concerning the sociodemographic profile, the mean age of the participants was 43.4 years (SD = 13.3, median = 43). Most of them were married, white, Catholic,

had one or two children, had no paid work, declared a family income of two to five minimum wages shared with approximately three people with whom they lived.

Among the participants, 44.7% ( $n = 63$ ) had paid work, 64% ( $n = 91$ ) reported having a profession

and only 9% (n = 8) of these women referred to professions of higher prestige such as administrator, accountant, commercial manager, engineer, business owner and teacher. Professions that require formal qualification, such as nursing technician, administrative assistant, sales promoter and invoice provider, were mentioned by 32% (n = 29) of women, while less prestigious occupations, such as maids, cleaning women, housekeepers, general service providers, and clerks, corresponded to 59% (n = 54) of the mentioned professions.

The suspected cases of mental disorder corresponded to 43.4% (n = 61) of the sample and

the distribution of these women according to their sociodemographic characteristics are presented in Table 1. As can be observed, there was a significant association between being a mother and having mental disorders.

Most of the interviewees were satisfied or very satisfied with their support network (average satisfaction score = 5.46, median = 5.7, SD = 0.72) and had six to nine supporters (mean = 7.7; median = 7; SD = 3.67). The most mentioned supporters were the children, the spouse and the parents. Of the total, only seven participants mentioned health professionals as supporters.

Table 1 - Distribution of participants according to sociodemographic characteristics and suspected cases of mental disorder (n = 141), Ribeirão Preto, SP, Brazil, 2017

Sociodemographic characteristics	Suspected case of mental disorder		Total n(%)	p-value
	Yes n(%)	No n(%)		
<b>Marital status</b>				
Out of stable union	18(12.8)	31(22)	49(34.8)	0.388*
In stable union	39(27.6)	49(34.7)	88(62.4)	
Non-informed	04(2.8)		04(2.8)	
<b>Cor</b>				
White or yellow	37(26.2)	44(31.2)	81(57.4)	0.501*
Black or brown	24(17.0)	36(25.5)	60(42.5)	
<b>Religion</b>				
Catholic	28(19.8)	40(28.4)	68(48.2)	0.629*
Non-Catholic	33(23.4)	40(28.4)	73(51.8)	
<b>Schooling</b>				
Incomplete high school or lower	35(24.8)	37(26.2)	72(51.0)	0.190*
Complete high school or higher	26(18.4)	43(30.5)	69(49.0)	
<b>Having children</b>				
Yes	58(41.1)	55(39.0)	113(80.1)	≤0.001†
No	3(2.1)	25(17.7)	28(19.8)	
<b>Exercise of paid activity</b>				
Yes	29(20.6)	34(24.1)	63(44.7)	0.534*
No	31(22.0)	45(31.9)	76(53.9)	
Non-informed	02(1.4)		02(1.4)	
<b>Income</b>				
Up to 2 minimum wages‡	32(22.7)	37(26.2)	69(48.9)	0.390*
Above 2 minimum wages‡	27(19.1)	42(29.8)	69(48.9)	
Non-informed	03(2.1)		03(2.1)	

\*Pearson's Chi-square test; †Fisher's exact test; ‡Brazilian minimum salary for the year 2017, which corresponded to R\$ 937.00

Table 2 shows the supporters mentioned according to the positive or negative status for mental disorder.

In the exploratory analysis, considering all participants, a significant association between having mental disorder and not referring friends as supporters was identified. In addition, most women who had mental disorders mentioned their children as supporters, suggesting a possible confounding factor in relation to the outcome presented in Table 1 (association between having mental disorder and being a mother).

Thus, a new test was undertaken that aimed to analyze the validity of such association, considering only the mothers. It was identified that of the 113 women who had children, 12 did not mention them as supporters (seven with suspected disorder and five without it). The association between having mental disorder and

mentioning children as supporters was not significant in the subgroup of the mothers participants ( $p = 0.763$  - Exact Fischer's Test).

Table 3 presents the most cited symptoms according to the social support score. As can be observed, women more satisfied with social support reported less symptoms of tiredness, sadness and were less likely to present a picture suggestive of mental disorder. There was a significant difference in the number of supporters only in relation to the fatigue symptom.

As can be observed in Figure 2, there was a negative correlation between satisfaction with support and suspicion of mental disorder ( $-0.374$ ;  $p \leq 0.001$ ). The correlation between this suspicion and the number of supporters was not significant ( $-0.142$ ;  $p = 0.094$ ).

Table 2 - Distribution of participants according to the composition of the support network and suspected cases of mental disorder (n = 141), Ribeirão Preto, SP, Brazil, 2017

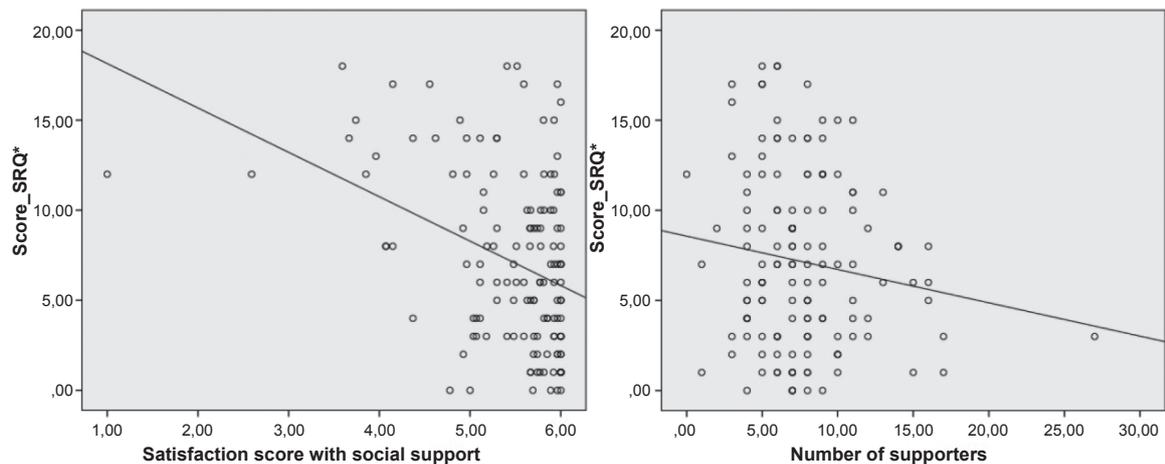
Composition of support network	Suspected case of mental disorder		Total n(%)	p-value
	Yes n(%)	No n(%)		
Spouse				
Yes	43(30.5)	58(41.1)	101(71.6)	
No	18(12.8)	22(15.6)	40(28.4)	0.793 <sup>*</sup>
Child				
Yes	51(36.2)	50(35.5)	101(71.7)	
No	10(7.1)	30(21.3)	40(28.4)	<b>0.006<sup>*</sup></b>
Siblings				
Yes	40(28.4)	51(36.2)	91(64.6)	
No	21(14.9)	29(20.6)	50(35.5)	0.823 <sup>*</sup>
Parents				
Yes	39(27.7)	54(38.3)	93(66.0)	
No	22(15.6)	26(18.4)	48(34.0)	0.658 <sup>*</sup>
Other family members				
Yes	32(22.7)	54(38.3)	86(61.0)	
No	29(20.6)	26(18.4)	55(39.0)	0.070 <sup>*</sup>
Friends				
Yes	22(15.6)	45(31.9)	67(47.5)	
No	39(27.6)	35(24.8)	74(52.4)	<b>0.017<sup>*</sup></b>
Religion				
Yes	04(2.8)	05(3.5)	09(6.3)	
No	57(40.4)	75(53.2)	132(93.6)	0.941 <sup>†</sup>
Co-workers				
Yes	04(2.8)	06(4.3)	10(7.1)	
No	57(40.4)	74(52.5)	131(92.9)	0.829 <sup>†</sup>
Neighbors				
Yes	02(1.4)	02(1.4)	04(2.8)	
No	59(41.8)	78(55.3)	137(97.1)	0.783 <sup>†</sup>
Health professionals				
Yes	05(3.5)	02(1.4)	07(4.9)	
No	56(39.7)	78(55.3)	134(95.1)	0.123 <sup>†</sup>

<sup>\*</sup>Pearson's Chi-square test; <sup>†</sup>Fisher's exact test

Table 3 - Relationship between social support and emotional and physical symptoms associated with psychiatric conditions (n = 141), Ribeirão Preto, SP, Brazil, 2017

Suspicion of common mental disorder and major symptoms	n(%)	Mean of social support score rank			
		Satisfaction with support	p-value	Number of supporters	p-value
Do you nervous, tense or worried?					
Yes	100(70.9)	67.5		71.65	
No	41(29.1)	79.4	0.114*	69.43	0.768*
Have you felt sad lately?					
Yes	72(51.1)	56.4		76.27	
No	69(48.9)	86.2	≤0.001*	65.50	0.115*
Do you get tired easily?					
Yes	59(41.8)	59.7		60.66	
No	82(58.1)	79.1	0.005*	78.44	0.010*
Suspected case of mental disorder					
Yes	61(43.3)	55.6		68.40	
No	80(56.7)	82.7	≤0.001*	72.98	0.507*

\*Mann-Whitney Test



\* Score\_SRQ – Self-Report Questionnaire Final Score

Figure 2 - Correlation between score of satisfaction with social support, number of supporters and score of Common Mental Disorder

The logistic regression analysis revealed that the satisfaction with the support and not having children were configured as protection factors in relation to the suspected mental disorder. That is, women who were not very satisfied with the received support [OR = 7.088 (CI 2.18-22.94),  $p = 0.001$ ] and were mothers [OR = 7.2592 (CI 2.01-26.17),  $p = 0.002$ ] had about seven times more chances of presenting a set of symptoms that characterized suspicion of mental disorder.

## Discussion

The results of the present study point to different issues related to gender inequality. One of them concerns the sociodemographic characterization of the participants, whose majority was married, with low family income and did not exercise paid activity. Those

who had a paid activity generally referred to professions culturally considered of low prestige.

These results corroborate the discussion on gender and health, emphasizing that the opportunities, responsibilities and roles socially associated with being a man or woman are an axis of social differentiation that interacts with other attributes such as age, race, income, family structure, education, and social support<sup>(18-20)</sup>. Thus, there is the need to consider the intersection of these attributes in the research and planning of women's health actions, since it is an important determinant of health and mental health<sup>(18-20)</sup>.

The fact that the main symptoms mentioned by the participants are fatigue, sadness, and nervousness corroborates a previous study<sup>(21)</sup>. This result, analyzed in the light of sociodemographic characteristics, refers us to a situation of vulnerability that combines

psychic and social aspects. The life context of these women contributes significantly to the increase of such symptoms, increasing the risks for presenting mental disorders.

Sadness, specifically, was mentioned by more than half of the participants of the present study. Although sadness alone does not determine a psychiatric condition, such symptom requires accurate contextualization and effective support for its management, since it contributes in an important way to the development of more severe conditions such as depression<sup>(22)</sup>.

Therefore, considering that women are at greater risk of developing depression<sup>(23)</sup> and that emotional complaints tend to be neglected in the face of other health demands<sup>(24)</sup>, the development of qualified listening spaces in primary care is recommended so as to provide comprehensive and welcoming assistance to the population, especially for women.

In this sense, it is worth mentioning that health professionals were the least mentioned supporters. The Family Health Units differ from the traditional Basic Units by the organization of their work process, with emphasis mainly on the size of the coverage area, attention to clients' specific characteristics, territorial approach, and work dynamics with periodic home visits<sup>(25-26)</sup>. In this logic, the proximity to the clientele and the closer ties with the community are crucial, assuming that such teams should be configured in effective references of support, especially in health-related needs<sup>(25-26)</sup>. Considering that all the participants were registered and have been accompanied by professionals of the Family Health Strategy and that the instrument used in the data collection mentioned some health-related issues, these professionals would be expected to be more relevant in the social support networks of these women.

The issue of access is thus an important element of this discussion, since the mere existence of a resource that can provide care or assistance does not necessarily guarantee that it is perceived as a supporter by the user<sup>(27)</sup>. Access to available resources implies aspects such as the type of reception offered, clarity about what the institution can provide the user, the resolution of the demands presented, and even the visibility of the role that the institution plays in the community<sup>(27)</sup>.

Regarding the suspected cases of mental disorder, the present study identified a lower percentage than the one indicated in previous studies carried out with women in the primary care level<sup>(21,28)</sup>. This difference may reflect the results related to social support. In this sense, the number and diversity of supporters, as well as the satisfaction with them, deserve to be highlighted because they were larger than those identified in previous research<sup>(29)</sup>.

Satisfaction with social support seems to play a protective role both in relation to the symptoms and the suspected disorder itself.

Friends and children were highlighted as supporters, corroborating studies that identified support from friends as a protective factor for women's mental health<sup>(12,30-31)</sup>. Thus, a network whose composition contains friends indicates a certain diversification in the sources of social support. Such a condition is considered beneficial to mental health, since friends can facilitate access to information and health services, encourage self-care, and provide more effective practical and/or emotional support in the face of family and/or marital problems<sup>(32-35)</sup>.

The results showed that having children constituted a significant risk factor in relation to the symptoms characteristic of mental disorders, corroborating previous research<sup>(28,36-37)</sup>. These results suggest that responsibilities with children, often attributed only to women, can contribute to task overload, high levels of stress, and increased symptoms of mental disorders<sup>(36)</sup>.

In spite of this, the children constituted one of the most mentioned groups of supporters, referring to the so-called "negative effect of social support". This effect concerns a duplicity of role played by the supporter, that is, the individual or institution can either provide support or become a source of stress because of the ambiguous character that marks some interpersonal relationships<sup>(36-39)</sup>. Therefore, the negative effect of social support should also be taken into account in planning health actions and future research.

Corroborating previous studies<sup>(11-12,40)</sup>, the results also pointed out that social support is a protective factor of possible cases of mental disorders. On the other hand, unlike previous research on social support and mental disorder in women, the present study analyzed two aspects of this construct, namely the number of supporters and the satisfaction with the support received. Negative correlation was identified for both aspects, but statistical significance was only for satisfaction with the support. This result highlights the need to consider that quality is as important as the other characteristics of social support, especially in studies that have psychosomatic issues as their object.

In summary, the present research identified that the satisfaction with the social support has, in fact, a protective effect in relation to mental disorders. In addition, children are important supporters, although "being a mother" was a risk factor for mental disorder among the women studied.

Regarding the implications for the practice, there is a need to strengthen the bond between health professionals and users, since the establishment of

links has been identified as promising for effective reception, improved communication among those involved, and facilitator in the identification of different health needs<sup>(41-42)</sup>. These aspects contribute to more comprehensive and supportive approaches and, consequently, to increase the perception of support by individuals.

In this sense, providing a listening that transcends the aspects traditionally considered clinical (those related to physical symptoms) and other actions that do not go beyond the scope of the skills of general practitioners could be adopted. Clarification on the care offered by the community service, especially those in the field of mental health, and the inclusion of emotional issues in the elaboration of individual Therapeutic Projects are some initiatives that, according to previous studies<sup>(43-44)</sup>, can contribute to broadening access to mental health care and to enabling health approaches from a more holistic perspective.

Strategies to improve the resolution of possible conflicts in the mother-child relationship are also important and could be achieved through qualified listening and support to the various maternal needs and distress in different life cycles. Qualified listening, as a light and relational technology, contributes to the individualization of the subjects and the extension of the technical capacity of the teams, especially in relation to the psychosocial demands in the community<sup>(45-46)</sup>. Another possibility would be the offering of rounds of conversation and group activities that provide the exchange of experiences between peers, as pointed out in previous studies<sup>(47-49)</sup>.

Promoting actions to improve stress management can also be relevant since it is associated with discussions on gender inequality in broader forums, aiming to dismantle the culture of assigning the role of caring for the family only to women, as well as combat the culture of submission, which permeates their daily lives. The importance of debating these themes is also reiterated in the literature<sup>(50-51)</sup>.

Thus, it is understood that such recommendations may be useful for primary care professionals and are within the scope of general practitioner skills. These actions may aid in broadening social support and reducing suffering that culminates in psychosomatic symptoms.

Among the limitations of this study, there is the fact that the sample was obtained only from one Family Health Unit, which makes it impossible to generalize the results. Although the gender cut was intentional in the present study, a survey that also included men could provide more conclusive results regarding the performance of the variable "having children" in the

relation between satisfaction with support and possible case of mental disorder.

Despite these limitations, we believe that the aspects listed in this research are extremely important in guiding and assisting the consolidation of mental health promotion practices. In addition, they corroborate the agenda of priorities and recommendations of the national and international health agencies, especially in the sense of integrating the promotion of gender equity in the expansion of access to mental health actions in primary health care<sup>(52-53)</sup>.

Furthermore, with regard to the external validity of the results, given the profile of the participants and the context of gender and health inequality in most low-income and middle-income countries, it is understood that the discussion and recommendations raised in the present study are applicable also to women in situations of social vulnerability in other regions of Brazil and even in other developing countries.

## Conclusion

The development of this research identified that women who were less satisfied with social support were more susceptible to presenting psychiatric conditions. In addition, the results suggest that gender-based distribution of roles may be a contributing factor for women who have children to be more susceptible to mental disorders.

Thus, both issues related to gender equity and satisfaction with social support should be considered in the planning of actions aimed at the promotion of mental health, especially in primary health care.

The undertaking of efforts in this direction implies to promote care that contemplate the subjective scope of the users, so that they feel more connected and supported by the formal and informal supporters available in their social environment and in the territory in which they live.

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