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Social Support, Self-Perceived Health and Mental Status of General Population of Republic of Srpska

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SUMMARY
Introduction Social support is defined as perception of how other people take care of us, how they understand our needs and give us support. Social support has positive influence on health, adoption of healthy lifestyles and recovery from illness.
Objective The aim of this paper is to detect the level of social support across different socio-demographic groups and to analyze relationship between social support, self-perceived health and mental well-being.
Methods Data from the 2010 Household Survey (National Health Survey) for the Republic of Srpska were used. A specially designed questionnaire was used, developed on the basis of internationally recognized and accepted instruments. Representative sample of 4,178 persons aged 18 and older were interviewed.
Results The obtained results showed that the level of social support was the lowest among the oldest population, persons with the lowest level of education unemployed and unmarried. There was present relationship between social support, self-perceived health and mental health (distress/stress and vitality). It was detected that males mostly lived alone relying on help from neighbors, while females mostly lived with other household members and relied more on persons close to them.
Conclusion Social support appears to be related to mental status and self-perceived health. The results are intertwined with different age groups and they can provide baseline for further analysis of causal relationship between social support and mental and physical health among different age categories. Detecting a link among social support, mental and physical health could provide insight into the mechanisms of social support influencing health status and behaviour.
Keywords: social support; health assessment; mental well-being

INTRODUCTION

Social support can be defined as the perception of how other people take care of us, understand our needs and respond to them [1, 2]. Such information can be obtained from a spouse, children, friends or other social contacts in the community, social clubs, etc. [1]. House and Kahn defined several types of social support depending on its primary functions; emotional support (showing concern, empathy and love, as well as the presence of someone with whom we can talk to), instrumental support (knowing there is someone who can help us in case of need) and assessment support (feedback that is useful for self-perception; someone whose opinion can be relied upon) [3]. According to Cohen and Wills [4], there are basically two ways in which social support can affect mental and physical health. First, social support may encourage people to take better care of themselves. For example, people important to us may persuade us to live a healthier life, simply because they care. Positive experience in stable social relationships also facilitate people to develop healthier life habits [1], although pressure of social peer networks can facilitate development of risk behavior (smoking, alcohol and drug use) [3]. Second, social support may positively affect health, because it buffers stress, and stress is directly associated with individual health. People better cope with stress knowing they have someone who can rely on, get advice or even solution for problems [1, 2, 5].

Social support is associated with mortality and morbidity [6, 7, 8], precisely, people who have more social relationships are in a lower risk of dying compared with those with little social connections [1]. According to surveys, people who have close, supporting relationships more successfully cope with life's problems, have better health [2], express healthier lifestyles, and they recover faster from disease [9]. Examining the impact of social support on health amongst patients who face stressful health problems (cancer, coronary disease etc.), the researchers have found that persons who enjoy more social support through self-help groups or by spouses recover faster from disease, and have greater emotional satisfaction, in comparison with the control group [1, 2, 10]. Most studies, however, show a positive effect of social support on the course of mental health, either as a direct or buffer effect [11].

OBJECTIVE

This paper focused on the level of social support amongst different socio-demographic groups so that the vulnerable groups of population with the lowest level of social support could be detected. Considering previous surveys of the effect of social support on health

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and healthy lifestyles, this survey examined the relationship between social support, self-perceived health and mental status amongst adult population of Republic of Srpska.

METHODS

Data presented in this paper were a part of the Household Survey (National Health Survey) conducted among adult population in the Republic of Srpska during 2010 [12]. The target population was people ≥18 years old that were present in the country minimally for one year and longer. A stratified two-stage representative sample of the population of Republic of Srpska was used. The units of the first stage were enumeration districts, the sampling units of the second stage were households. The total number of households selected for the survey was 1,866. The total of 4,178 adults was interviewed.

Instrument and variables

Specially designed questionnaire was used for the survey which was developed on the basis of internationally recognized and accepted instruments. Information was obtained through a face-to-face interview carried out at home. From the original instrument, 18 questions were used for the purpose of this paper from sections related with socio-demographic characteristic, social support, mental health and self-perceived health.

From the section related with socio-demographic characteristics five questions were used; gender (females and males), age (categorized in 10 years age groups: 25 to 34 years, 35 to 44 years etc.), education level (low, middle, high), marital status (married, living with partner, not married/divorced/widowed), employment (employed, unemployed and inactive).

Three questions were identified for assessing social support (National Health Survey – recommendation from: Finbalt, SF 36 questionnaire, WHO Health Survey, ECHI – Child Project, CDC National Health Interview Survey); assessment of possibility of getting support from neighbors when it was needed estimated by using Likert scale (1 – very difficult to 5 – very easy), assessments of the number of people that could be counted on in the event of serious personal problems assessed by a four degree scale (1 – no one to 4 – more than 5 persons) and the question related to whether a person lives alone or with other household members (yes/live alone; if yes, then with a specified number of household members).

European Health Interview (EUROHIS) and European Community Health Indicators Monitoring (ECHIM) considered psychological distress and positive mental health as important measures of mental health on the population level [13, 14]. Form on the instrument SF-36 (Mental Health Indicator 5 or MHI5) was used for measuring mental distress and they were a part of survey instrument. MHI5 consisted of five items that measured the level of negative/positive emotional states through the Likert scale with possible scores ranging from 0 to 100 in which the higher score indicated better mental health and vice versa. Positive mental health (vitality) was measured by the vitality scale of SF-36. The mentioned scale was used to measure the level of positive mental health with four items, i.e. the presence of energy levels, agility and vitality through the Likert scale. Scores ranged from 0 to 100, with a higher score indicating a greater vitality and vice versa. One question on the Likert scale was used for measuring self-perceived health (1 – very bad to 5 – very good).

Data collection

Field work was conducted by teams of interviewers from primary health centers. One team consisted of two interviewers; two medical workers who had always worked together. All members of households who met the criteria of target population were interviewed.

Statistical analysis

Frequencies of social support measures among different socio-demographic groups were examined and differences were calculated using the χ^2 test. In order to estimate the association of variables of social support and age with self-perceived health and mental status (distress and vitality), multivariate logistic regression models were used (one model for each dependent variables; self-perceived health, mental stress and vitality). All selected independent variables (age, number of household members, help from neighbors, and the number of people that one can rely on) were included in the final models and all analyses were carried out separately for males and females. The probability, $p<0.05$ was used as the minimal level of significance. The analyses were conducted using the statistical software package SPSS version 16.

RESULTS

Since the study included a variety number of general population (≥18), first we focused on the presence of social support among different socio-demographic groups. There are statistically significant differences in the number of household members among different population categories. Males (71.7%) and persons older than 55 (85.3%) mostly live alone. The same situation was found to be present among population with a lower level of education (68.1%) and inactive persons (retired, housewives of disabled). A significantly higher percentage of persons who are not married, divorced or who are widowed (97.8%) live alone in comparison with others who live in marriage or with a partner who mostly live with other household members (70.5%) (Table 1).

Percentage of person who can rely on others in case of serious personal problem is slightly higher among females

Table 1. Number of household members among different socio-demographic groups of adult population

Variable		Households with more than one member				p (χ^2 test)
		Yes		No (live alone)		
		N	%	N	%	
Gender	Male	2048	52.6	200	71.7	0.000
	Female	1842	47.4	79	28.3	
	Total	3890	100.0	279	100.0	
Age (years)	18–24	378	9.7	0	0.0	0.000
	25–34	556	14.3	7	2.5	
	35–44	639	16.4	12	4.3	
	45–54	812	20.9	22	7.9	
	55–64	685	17.6	68	24.4	
	≥65	820	21.1	170	60.9	
	Total	3890	100.0	279	100.0	
Education	Low	1507	38.8	190	68.1	0.000
	Middle	2005	51.6	70	25.1	
	High	374	9.6	19	6.8	
	Total	3886	100.0	279	100.0	
Employment	Employed	1210	31.1	24	8.6	0.000
	Unemployed	956	24.6	37	13.3	
	Inactive	1722	44.3	217	78.1	
	Total	3888	100.0	278	100.0	
Marital status	Married or living with partner	2734	70.5	6	2.2	0.000
	Not married, divorced, widowed	1145	29.5	273	97.8	
	Total	3879	100.0	279	100.0	

than males (p=0.011). Comparing variables of social support among different age categories we noticed that the number of person and neighbors that one could rely on or seek for help statistically significantly decreased among older population (≥55) in comparison with younger ones. The presence of social support was significantly lower among persons with a low level of education in comparison with persons with middle education (3 or 4 year high school). It is evident that persons with a high level of education perceive more availability of help from persons that one can rely on (11.7%) than from neighbors (8.1%). Unemployed and inactive persons perceive more that they do not have anybody to rely on than persons who are employed (p=0.007). Persons who are single, divorced or widow/widower have significantly less persons who they can rely on in case of serious personal problems (29.9% have more than 5 persons) than others who live in marriage or with partner (70.1% have more than 5 persons) (Table 2).

For the evaluation of the possibility of age and social support indicators (number of household members, ability to rely on help of neighbors and the number of people we can count on in case of a serious problem) to provide relationship with self-perceived health, level of distress and positive mental health (vitality) multiple regression was applied. The model as a whole explained 33.6% of the total variance of global health assessment, 12.5% of the total variance of levels of distress and 20.5% of the total variance vitality. This model is a significant predictor of self-perceived health (F=528.686; p<0.001), distress (F=149.938; p<0.001) and vitality (F=269.519; p<0.001).

All variables in the model give a statistically significant and unique contribution to the prediction of dependent variables. The largest negative association is present between self-perceived health and age (p<0.001). The same variable (age) is most negatively associated with distress (p<0.001) and vitality (p<0.001), while help from the neighbors is positively associated with mental distress (Table 3). Next, by comparing males and females, a negative association was found between self-perceived health and age (p<0,001) in both groups, while among males a positive association between self-perceived health and help from neighbors was present (p<0.001). Among males a negative association between age and distress (p<0.001) and a positive association between help from neighbors and mental distress were present (p<0.001). However, among females a negative association between distress and age (p<0.001) and a positive association between distress and persons that they can rely on were present (p<0.001). A negative association of age on mental vitality was large for males and females, although the association of vitality and help from neighbors was more present among males (Table 3).

DISCUSSION

The level of social support varies across different categories of population. Reduced number of people and neighbors from whom one can seek help is present among older categories of population. A low presence of social support is evident among inactive (retired, housewives and disabled) persons, persons with the lowest level of education and whose who live alone (divorced, widowed, unmarried). Also, males, more than females, live alone and rely on a smaller number of persons in case of serious problems. The presented groups of persons were more vulner-

Table 2. Level of social support among different socio-demographic groups of adult population

Variable		Can get help form neighbour when it is needed – N (%)			p	No. of persons one can rely on when there is a serious personal problem – N (%)			p (χ^2 test)
		Hard	Possible	Easy		No one	1–5	> 5	
Gender	Male	42 (50.6)	1177 (54.4)	762 (54.9)	0.747	36 (46.2)	1726 (55.2)	492 (50.4)	0.011
	Female	41 (49.4)	985 (45.6)	627 (45.1)		42 (53.8)	1398 (44.8)	484 (49.6)	
	Total	83 (100.0)	2162 (100.0)	1389 (100.)		78 (100.0)	3124 (100.0)	976 (100.0)	
Age (years)	18–24	4 (4.8)	183 (8.5)	137 (9.9)	0.046	1 (1.3)	272 (8.7)	108 (11.1)	0.001
	25–34	7 (8.4)	283 (13.1)	175 (12.6)		7 (9.0)	409 (13.1)	147 (15.1)	
	35–44	11 (13.3)	306 (14.2)	242 (17.4)		8 (10.3)	488 (15.6)	159 (16.3)	
	45–54	22 (26.5)	433 (20.0)	284 (20.4)		20 (25.6)	613 (19.6)	203 (20.8)	
	55–64	16 (19.3)	398 (18.4)	246 (17.7)		16 (20.5)	563 (18.0)	174 (17.8)	
	≥65	23 (27.7)	559 (25.9)	305 (22.0)		26 (33.3)	779 (24.9)	185 (19.0)	
	Total	83 (100.0)	2162 (100.0)	1389 (100.0)		78 (100.0)	3124 (100.0)	976 (100.0)	
Education	Low	47 (56.6)	920 (42.6)	538 (38.8)	0.001	48 (61.5)	1330 (42.6)	319 (32.7)	0.000
	Middle	27 (32.5)	1035 (47.9)	736 (53.1)		25 (32.1)	1514 (48.5)	542 (55.6)	
	High	9 (10.8)	204 (9.4)	113 (8.1)		5 (6.4)	276 (8.8)	114 (11.7)	
	Total	83 (100.0)	2159 (100.0)	1387 (100.0)		78 (100.0)	3120 (100.0)	975 (100.0)	
Employment	Employed	13 (15.7)	622 (28.8)	406 (29.3)	0.073	10 (12.8)	916 (29.3)	311 (31.9)	0.007
	Unemployed	28 (33.7)	517 (23.9)	331 (23.8)		26 (33.3)	737 (23.6)	231 (23.7)	
	Inactive	42 (50.6)	1020 (47.2)	651 (46.9)		42 (53.8)	1468 (47.0)	433 (44.4)	
	Total	83 (100)	2159 (100.0)	1388 (100.0)		78 (100.0)	3121 (100.0)	975 (100.0)	
Marital status	Married or living with partner	53 (63.9)	1387 (64.4)	940 (67.8)	0.108	47 (60.3)	2014 (64.7)	683 (70.1)	0.004
	Not married, divorced, widowed	30 (36.1)	766 (35.6)	446 (32.2)		31 (39.7)	1100 (35.3)	291 (29.9)	
	Total	83 (100.0)	2153 (100.0)	1386 (100.0)		78 (100.0)	3114 (100.0)	974 (100.0)	

Table 3. Association of self-perceived health, mental distress and mental vitality with age and variables of social support in the total sample and according to gender: results of multivariate logistic regression

Variables		β (p)		
		Total	Males	Females
Model for self-perceived health*	Age	-0.550 (<0.001)	-0.493 (<0.001)	-0.602 (<0.001)
	No. of household members	-0.018 (0.171)	-0.031 (0.109)	-0.010 (0.585)
	Help from neighbors	0.075 (<0.001)	0.104 (<0.001)	0.055 (0.003)
	No. of people who can be relied on	0.060 (<0.001)	0.051 (0.022)	0.059 (0.002)
	Adjusted R^2	0.336	0.282	0.379
Model for mental distress**	Age	-0.198 (<0.001)	-0.170 (<0.001)	-0.223 (<0.001)
	No. of household members	-0.091 (<0.001)	-0.113 (<0.001)	-0.065 (0.002)
	Help from neighbors	0.163 (<0.001)	0.220 (<0.001)	0.127 (<0.001)
	No. of people who can be relied on	0.109 (<0.001)	0.047 (0.056)	0.147 (<0.001)
	Adjusted R^2	0.125	0.118	0.129
Model for mental vitality***	Age	-0.392 (<0.001)	-0.356 (<0.001)	-0.425 (<0.001)
	No. of household members	-0.059 (<0.001)	-0.063 (0.003)	-0.040 (0.043)
	Help from neighbors	0.134 (<0.001)	0.197 (<0.001)	0.091 (<0.001)
	No. of people who can be relied on	0.031 (0.050)	-0.019 (0.427)	0.058 (0.005)
	Adjusted R^2	0.205	0.184	0.220

* males: F=189.681; p=0.000; females: F=344.355; p=0.000
** males: F=64.924; p=0.000; females: F=84.419; p=0.000
*** males: F=109.300; p=0.000; females: F=159.300; p=0.000

able since the lack of social support could deteriorate their health, especially with aging. Therefore, integrated social networks provide more social support to seniors and have a positive impact on mental and physical health, while loneliness and social isolation are associated with health problems and chronic conditions in older population [15]. Effects of reduced social support on health and life satisfaction among older population groups become more important since aging population is a growing problem.

The influence of social support is significant but small in terms of self-perceived health, while it is slightly higher in terms of distress and vitality (mental status). The influence of age on self-perceived health and mental status is much greater, so we can conclude that the level of health status satisfaction and mental health decreases with aging. Also, the impact of social support on the level of distress and vitality confirms the influence of social support on mental health [16, 17]. Researchers confirm that perceived

social support has a positive effect on mental health, i.e. reduces psychological distress, depression and anxiety [3, 4]. Previous research suggests that one's perception of having social support when it is needed is associated with a better mental status (distress and vitality). Self-reported or perceived low social support is indeed the risk factor for a poorer health status [18]. When it comes to gender differences, the impact of connections with neighbors on mental distress is higher among males while for female aging is more related to mental distress. According to our results, ageing is also an important risk factor for mental and self-perceived health which can be partially explained with living conditions and a small income of retired persons. More accurate measures of the life-span perspective of social capital and perceived social support [6] are important for revealing gender and age differences.

The presented results partially confirm theoretical hypothesis about the buffering effects of social support. Persons who live in the community, who feel that they can rely on a wider range of people have positive mental health and greater satisfaction with life. Capacity to cope with stress is higher due to the increased level of self-control mechanism that supports overcoming stressful events [19]. By comparing males and females we can notice that the impact of ageing on self-perceived health and mental status is important for both groups, but the social support impact of perceived help from neighbors on mental stress and vitality is more present among males than females. Females are more relied on persons who they can count on if some serious problem emerges. This difference can be partially explained by the fact that males live alone more often than females so they mostly rely on close neighbors while females have more household members that they can rely on.

Since the presented results are a part of a much bigger population survey, there are some dilemmas which we have to stress out. Social support and different age categories are overlapping and leave uncertainties in the interpretation of results, so that a more detailed analysis (based on a comparison of different socio-demographic groups in the population) could provide insight into the processes that mediate the effects of social support on health status. Also, some parts of applied instrument are not so sensitive measures of social support, so that there is an open question of the appropriateness of social support indicators. Further linking of these results with objective parameters of health status would provide a more accurate relation of social support with mental health and health status between the different age categories of population. Comparing the impact of social support on mental and physical health across different socio-demographic groups (unemployed, unmarried etc.) will certainly reveal all factors which together with social support have a great impact on health. Further analyses could reveal mediating factors which have impact, together with social support, on health status and mental state of older population.

CONCLUSION

The study suggests differences in the level of social support between different age categories and socio-demographic groups. The level of social support is the lowest among the oldest population, persons with low education who are unemployed and single. With aging there is the presence of the lower level of self-perceived health and mental stress and vitality. Males mostly rely on help from neighbors while females mostly expect support from important persons whom they can rely on. These variables are mostly associated with mental health. The presented indicators limit the capacity of fine distinction of the structural and functional aspect of social support. However, the present study is nationally representative and contains a comprehensive set of demographic variables which reveal relationship among social support, self-perceived health and mental status. Wise socio-psychological support measures are urgently needed with a primary focus on the most socially disadvantaged socio-demographic groups.

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Социјална подршка, самопроцена здравља и ментално здравље становништва Републике Српске

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КРАТАК САДРЖАЈ

Увод Социјална подршка значи процену онога колико се други људи брину за нас, прихватају наше потребе и пружају нам подршку. Њен значај се огледа у позитивном утицају на здравље, усвајању здравих стилова живота и опоравку од болести.

Циљ рада Циљ рада је био да се утврде заступљеност социјалне подршке међу различитим групама становништва и њен утицај на ментално благостање и процену општег здравља.

Методе рада Истраживање је урађено као студија пресека међу одраслим становништвом на територији Републике Српске. У истраживању је коришћен посебно дизајниран упитник осмишљен на основу међународно потврђених и прихваћених инструмената са посебно издвојеним питањима у области социјалне подршке, самопроцене здравља и менталног здравља. Укупно 1.866 домаћинстава је обухваћено истраживањем, а анкетирано је 4.178 лица.

Резултати Добијени резултати су показали да је ниво социјалне подршке, изражен кроз број чланова домаћинства, суседе од којих особа може тражити помоћ, те особе на које се неко може ослонити, нижи код најстаријих категорија становништва, особа с најнижим нивоом образовања, незапослених и оних који не живе у брачној заједници. Заступљен је утицај социјалне подршке на процену општег здравља и ментално здравље (дистрес/стрес и виталност). Поредећи мушкарце и жене, може се уочити да мушкарци у већем проценту живе сами, те више очекују помоћ од суседа у случају потребе, док жене живе са другим члановима породице и више се ослањају на помоћ супруга.

Закључак Очигледан је утицај социјалне подршке на процену здравља и ментално благостање. Добијени резултати се преплићу с различитим старосним категоријама, те представљају основу за дубље анализе и утврђивање узрочних односа између социјалне подршке и менталног здравља становништва. Утврђивање процеса који посредују између утицаја социјалне подршке и физичког и менталног здравља пружило би увид у механизме њеног утицаја на здравствено стање и понашање.

Кључне речи: социјална подршка; процена здравља; ментално благостање

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