



Does social support protect against depression & psychological distress? Findings from the RELACHS study of East London adolescents



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A B S T R A C T

Keywords:

Social support
Psychological distress
Depressive symptoms
Ethnicity

Few prospective studies have examined the relationship between social support and psychological distress and depressive symptoms in adolescents. The aims of this study were to test whether social support is protective against psychological distress and depressive symptoms in an ethnically diverse population of adolescents and whether differences in support are reflected by ethnic differences in psychological distress and depressive symptoms. Based on a longitudinal survey of 821 adolescents, this study found low levels of social support from family members was prospectively associated with depressive symptoms (OR = 2.25, 95% CI 1.43–3.54). Compared with White UK pupils, Black pupils were less likely to display psychological distress (OR = 0.21, 95% CI 0.09–0.51). However, social support did not explain the ethnic variations in psychological distress. Family environment may be a more consistent source of support compared with support from peers. The lower risk of psychological distress among Black pupils compared to White pupils requires further investigation.

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Introduction

The incidence of unidentified and untreated mental health problems during adolescence is a major public health concern, as outlined by The New Horizons consultation document (Department of Health, 2009). Prevention of these problems at a population level is possible by identifying and promoting factors that protect mental health. The World Health Organization (2010) defines mental health as ‘the positive foundation for individual well-being and the effective functioning of a community’. A substantial amount of research involving mental health in adolescents has focussed on measures of psychological distress, such as non-psychotic emotional and behavioural difficulties as opposed to psychotic symptoms (Angold, 1988; Collishaw, Maughan, Goodman, & Pickles, 2008; West & Sweeting, 2003). Behavioural difficulties can include symptoms of hyperactivity, conduct disorder or peer relationship problems. On the other hand, emotional difficulties can include symptoms of depression or anxiety. Psychological distress is a term frequently used in health care literature, though the term is seldom defined. Ridner (2004) proposes that psychological distress refers to the unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person.

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There is a growing amount of evidence that indicates that social support is a protective factor for mental health that moderates the effect of risk factors during adversity (Barrera, Fleming, & Khan, 2004; Cohen & Wills, 1985). Social support has been documented to influence the risk of mental ill-health, particularly depressive symptoms (e.g. George, Blazer, Hughes, & Fowler, 1989), in adults. There is also evidence to suggest that a low level of social support from parents is associated with an increase in depressive symptoms during adolescence (Stice, Ragan, & Randall, 2004). Definitions of social support vary widely; Cohen and Syme (1985) provide a broad definition of social support as ‘the resources provided by other persons’. Social support encompasses a range of social interactions including emotional, informational and more tangible types of support. Most studies of social support measure the perceived availability of support, as we do in this study, rather than received support, which is more difficult to measure by self-report questionnaires (Bal, Crombex, Van Oost, & Debourdeaudhuij, 2003). Received support may be a more objective measure of actual support provided, but nevertheless, perceptions of available support have been found to affect mental health (Barrera & Garrison-Jones, 1992).

The mechanism of the effects of social support upon mental health, operate by two, though not mutually exclusive, means: by having a direct and positive effect on mental health, or by buffering the effects of adverse events that may cause psychological distress and depressive symptoms i.e. moderate the risk of adversity.

There is evidence to suggest that low levels of support are prospectively associated with depressive symptoms amongst adolescents (Galambos, Leadbeater, & Barker, 2004; Murberg, 2009; Sheeber, Hops, Alpert, Davis, & Andrews, 1997). However, the direction of causality is not always clear and some research has found evidence suggesting that people experiencing depressive symptoms are less likely to seek out support (Coyne, 1976).

A prospective study (RELACHS) of a multi-ethnic sample of school pupils, aged 11–14 years, was conducted in East London, which found lower levels of psychological distress amongst Bangladeshi pupils and higher levels of depressive symptoms amongst non-UK born White pupils (Stansfeld et al., 2004). This led to the investigation of factors that might protect against psychological distress in different ethnic groups, for example, social support. In cross sectional analyses in the RELACHS study, Klineberg et al. (2006) found that low perceived social support was associated with poorer mental health amongst an adolescent sample. The findings suggested that both social support and ethnicity had independent effects upon psychological distress and depressive symptoms, but social support did not explain ethnic variations in psychological distress.

Time spent with family activities may be a proxy for high levels of family social support. In another multi-ethnic study of adolescents, Maynard and Harding (2010) found evidence for ethnic variations in time spent in family activities, where UK minority adolescents were more likely to participate in family activities compared with White UK adolescents. Furthermore, based on evidence gathered from both adult (Stansfeld & Sproston, 2002) and adolescent populations (Costello, Farmer, Angold, Burns, & Erkanli, 1997), there has been some speculation about whether overall better mental health reported by particular ethnic groups is due to experiencing the protective effects of social support, shaped by cultural expectations of ideal family environments and parenting practices. Evidence of an association between ethnicity and mental health amongst adolescents, perhaps mediated through social support, was found in The Great Smoky Mountains Study (Costello et al., 1997). This study involved a population-based community survey of 1073 9–16 year old children, revealing that American Indian adolescents displayed much higher rates of family deviance, family adversity and poverty than did White adolescents. However, associations between poverty, family deviance and overall prevalence of psychiatric disorders were significant for the White community but not the American Indians. American Indian children also displayed a lower overall prevalence of psychiatric disorders than the White sample. The authors speculate whether an ‘American Indian way of life’ may have particular protective characteristics. The Great Smoky Mountain study did not examine differences in levels of social support according to ethnicity. The cross-sectional nature of this study could not establish the direction of association between social support and mental health. One way in which the direction of effect between social support and mental health might be disentangled is by using a prospective study design.

This paper examines prospective associations between social support and an overall measure of psychological distress and a specific measure of depressive symptoms amongst an ethnically diverse adolescent population.

The hypotheses for this study were:

Hypothesis (1). Low social support leads to greater psychological distress and depressive symptoms at follow-up.

Hypothesis (2). Low social support may account for ethnic variations in psychological distress and depressive symptoms at follow-up.

Method

Study design and sample

‘Research with East London Adolescents: Community Health Survey’ (RELACHS) is a prospective cohort study involving schools across Hackney, Newham and Tower Hamlets. In 2001 (study baseline), 30 out of 42 secondary schools in East London were randomly selected and balanced to represent single and mixed sex schools. Eligible schools were stratified by borough and school type (comprehensive, voluntary and other); 28 schools agreed to participate. In each of the 28 schools, two representative mixed ability classes were selected from both Year 7 (11–12 years) and Year 9 (13–14 years). These pupils were followed up in 2003.

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