Original Article

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Psychological Distress, Family Relationship and Reasons for Consultation of Women from Arequipa, Peru

Malestar Psicológico, relación con la familia y motivo de consulta en mujeres de Arequipa, Perú

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Summary

Objective: to analyze the association between psychological distress, family relationships and reasons for consultation of women who attended a health center in the city of Arequipa, Peru. **Method:** cross-sectional study, 134 women from different socioeconomic strata participated. The Kessler Psychological Distress Scale and a sociodemographic data sheet were applied. **Results:** It was determined that 30.6% of the sample suffered from psychological distress, which was associated with educational level, socioeconomic level, perception of family relationships and headaches. **Conclusions:** psychological distress may be conditioned by psychosocial variables such as family, education and socioeconomic status; this has an impact on the physical health of affected people.

Keywords: Psychological Distress, Women, Mental Health, Family

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Resumen

Objetivo: analizar la asociación entre malestar psicológico, relaciones familiares y el motivo de consulta de mujeres que acudieron a un centro de salud en la ciudad de Arequipa, Perú. **Método:** estudio transversal, participaron 134 mujeres de diferentes estratos socioeconómicos a las que se les aplicó la escala de Malestar de Kessler y una ficha de datos sociodemográficos. **Resultados:** Se determinó que 30.6% de la muestra presentó malestar psicológico, asociado al nivel educativo, nivel socioeconómico, percepción de las relaciones familiares y padecimiento de cefaleas. **Conclusiones:** el malestar psicológico puede estar condicionado por variables psicosociales como la familia, la educación y el estatus socioeconómico, esto tiene un impacto en la salud física de las personas afectadas.

Palabras clave: malestar psicológico, mujeres, salud mental, familia

Introduction

Psychological distress is a clinical entity that refers to a set of cognitive, emotional and behavioral manifestations that are characterized by their short course, rapid evolution and good prognosis.[1] It is a non-diagnostic construct, that has great preventive value, because psychological distress alludes to phases that prelude the appearance of mental disorders or clinically significant symptoms. The conceptual core of which focuses primarily on depression, but encompasses symptoms such as anxiety, stress, anger, somatization, hopelessness and emotional exhaustion.[2] Hence, it has some relevance in the field of preventive health and primary family care, because psychological distress is a predictor of various mood disorders and its evaluation constitutes a screening assessment of mental health.[3]

Among the causes of psychological distress, there are various factors, some are social such as migration and living conditions, others are socioeconomic and occupational aspects.[4,5] In this context, it has been reported that sex and educational level are factors associated with psychological distress, that condition is more frequent in women and people with a low level of education.[6] Other studies have linked psychological distress with substance use and lack of social support,[4] as well as low academic performance in students and lack of motivation in studies.[7] It has also been noted psychological distress is more frequent during adolescence and during certain vital situations such as pregnancy.[8, 9]

On the other hand, psychological distress in men has been associated with family, economic, psychological and health factors, such as muscle pain, insomnia, nightmares and changes in behavior.[10]

Women have high risk of suffering psychological distress, which is usually the prelude to more serious psychopathological symptoms, and, in relation to various social and family pressures.[11] It has been determined family plays an important role as a source of support against the appearance of manifestations of psychological distress. Therefore, family intervention is necessary at different levels, which could include counseling, evaluation of family functionality, and family therapy.[12,13]

Psychological discomfort in women has been related to age,[11,12] low level of schooling,[6] academic overload and poor family relationships,[14] and high risk pregnancy, when the woman does not have support from their couples.[6,11,12,14,15] The incidence of this condition in average women was 36%;[14] while in pregnant women, the figure raised to 62%[9] and the problem usually manifests itself as anxiety and depression.

Psychological discomfort is associated with emotional disturbances,[16] eating disorders or impulse control problems,[2] psychophysiological disorders such as asthma and respiratory diseases, muscle pain and sleep disorders, among others, are also involved in its development.[10,12] For that reason, this study tries to analyze the association between psychological distress, family relationships and the reasons for consultation of women who attended a health center in the city of Arequipa, Peru.

Method

Cross-sectional study.[17] The sample included 134 women who went to a health center in the city of Arequipa, they were selected through a non-probability sampling and the quota sampling technique.[18] For data collection, a sociodemographic file was used, which contained the following information: age, educational level, occupation, socioeconomic status, origin (rural or urban), marital status and the perception of the relationship with the family, the latter was assessed by means of a simple question that offered three alternative responses (poor, regular and good).

In addition, the Kessler Psychological Discomfort Scale was applied,[19] this screening instrument consists of ten items of non-specific manifestations of psychological distress related to depression. Its Latin American version was validated in Argentina by Brenlla and Aranguren,[6] who ratified its one-dimensional structure and reported adequate

reliability indices and a cut-off point of 24.5, to discriminate between those who have or do not have psychological distress. The version used in this investigation was validated in Arequipa by Arias et al.,[2] and it has adequate reliability indices, such as Cronbach's alpha (∝=0.901) and McDonald's Omega (ω=0.899). An exploratory factor analysis indicated that the scale had an underlying factor to the psychological distress construct, with adequate goodness of fit indexes.

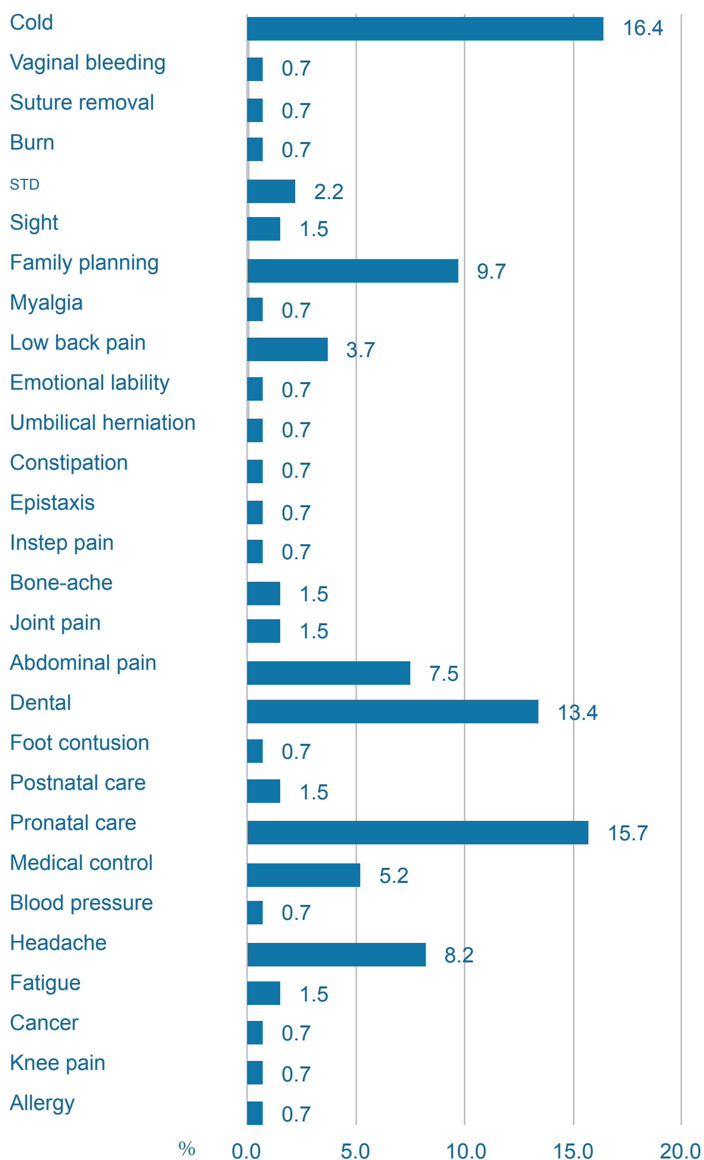
The authorities of the health center gave permission to carry out this study and the Ethics Committee of the Catholic University of Santa María approved its execution. The sample of women was examined in the general medicine office in a health center, the purposes of the study were explained to them and the research instruments were applied. All women voluntarily participated and signed the informed consent; all of them agreed to use their data for research purposes.

For statistical analysis, the SPSS software v. 21 was used. Descriptive and inferential statistical tests were conducted depending on the level of measurement of the variables and the normality of the data. Student's t-test, analysis of variance, Pearson's correlation coefficient and χ^2 were applied.

Results

The average age of the evaluated women was 34 years (± 11.77), range from 18 to 70 years. Regarding the educational attainment, 2.2% was illiterate, 17.2% had primary education, 57.5% had secondary education, 17.9% had technical training and 5.2% had professional training. In reference to socioeconomic status, 5.2% was in low, 90.3% in middle and 4.5% in upper class. According to their origin, 23.9% came from rural areas and 76.1% from urban areas. In relation to marital status, 14.9% were single, 19.4% married, 1.5%, divorced, 3%, widowed, 5.2%, separated and 56% lived in union. Concerning their occupation, 61.2% were housewives, 23.1%, worked independently, 2.9% were merchants, 6.7%, students, while 6.1% stated that they had other occupations. Perception of family relationship was poor in 3% of the cases, fair in 50% and good in 47% of the women. Likewise, psychological distress had a mean of 22.36 (± 6.03), range from 12 to 43. Taking the cut-off point of 24.5 reported by Brenlla et al.,[6] it was found that 69.4% of the sample did not present psychological discomfort, while that 30.6% suffered from it.

Figure 1. Reasons for consultation



The most frequent reasons for consultation were cold (16.4%), prenatal control (15.7%), dental care (13.4%), family planning (9.7%), headache (8.2%), abdominal pain (7.5%), medical control (5.2%), and low back pain (3.7%), see figure 1.

Data analysis revealed there were no significant differences in psychological distress depending on the place of origin, marital status or occupation. However, there were significant differences based on educational level, socioeconomic status and perception of the family relationship. In this context, the analysis of variance and the Bonferroni post-hoc test showed that women with secondary or technical education have higher levels of psychological distress than those with professional studies (F= 3,001; df= 133; p= 0.021). Women with high socioeconomic status presented less psychological distress compared to women with low socioeconomic status (F= 3,830; df= 133; p= 0.024). While women who had bad family relationship had greater psychological distress than those who had regular family relationship. Besides, both groups reported having greater psychological distress compared to women who reported a good level (F= 30,379; df= 133; p= 0.000). Additionally, age was significantly correlated with psychological distress (r= 0.176; p= 0.042).

Finally, when crossing variables between the reasons for consultation and psychological distress as a categorical variable (with or without distress), it was determined there is a significant association between headaches with psychological distress, see table 1.

Table 1. Data crossing: psychological distress and reasons for consultation

Reasons for consultation	Diagnosis		Total
	Without psychological distress Frequency (%)	With psychological distress Frequency (%)	
Allergy	1 (100%)	0 (0%)	1
Knee pain	1 (100%)	0 (0%)	1
Cancer	1 (100%)	0 (0%)	1
Fatigue	0 (0%)	2 (100%)	2
Headache	3 (27.3%)	8 (72.7%)	11
Blood pressure	0 (0%)	1 (100%)	1
Medical control	6 (87.5%)	1 (14.3%)	7
Prenatal care	15 (71.4%)	6 (28.6%)	21
Postnatal care	2 (100%)	0 (0%)	2
Foot contusion	1 (100%)	0 (0%)	1
Dental	16 (88.9%)	2 (11.1%)	18
Abdominal pain	8 (80%)	2 (20%)	10
Joint pain	2 (100%)	0 (0%)	2
Bone-ache	2 (100%)	0 (0%)	2
Instep pain	1 (100%)	0 (0%)	1
Constipation	0 (0%)	1 (100%)	1
Umbilical herniation	0 (0%)	1 (100%)	1
Emotional lability	0 (0%)	1 (100%)	1
Low back pain	2 (40%)	3 (60%)	5
Myalgia	1 (100%)	0 (0%)	1
Family planning	8 (61.5%)	5 (38.5%)	13
Sight	2 (100%)	0 (0%)	2
STD	2 (66.7%)	1 (33.3%)	3
Burn	0 (0%)	1 (100%)	1
Suture removal	0 (0%)	1 (100%)	1
Vaginal bleeding	1 (100%)	0 (0%)	1
Cold	18 (69.4%)	4 (30.6%)	22

x2= 44.909; gl= 27; p= 0.017

Discussion

Psychological distress is characterized by its reactive nature in the face of certain

stressful events, emotional disturbances that accompany it, and ego-dystonic experimentation of its clinical manifestations.[1] In this sense, psychological distress has been associated with various psychological disorders,[2,16] medical illnesses and psychophysiological disorders.[10,12] This study indicates psychological distress is associated with headaches reported by the evaluated women as their reason for consultation.Which is consistent with the fact that headache is one of the recurrent psychosomatic manifestations in anxiety and mood disorders, two of the most frequent symptoms in the female population of the city of Arequipa.[20]

Educational attainment was associated with psychological distress. Women with secondary and technical studies are those who have higher scores on psychological distress, compared to women with university studies. These results are similar to those reported by Brenlla and Aranguren.[6] Moreover, low socioeconomic status is related to high psychological distress and viceversa. Herrera and Rivera[14] reported socioeconomic status is associated with psychological distress significantly in women studying nursing in Chile.

Regarding family, negative perception of family relationship is related to high psychological distress, which is consistent with other studies that indicate family support and family functionality are important predictors of psychological distress or that they are associated.[4,14] That highlights the importance of the family approach in medical care.[21]

New studies must overcome the limitations of this research. In that way, it is required a probabilistic and more representative selection of sample, as well as the inclusion of other variables related to psychological distress. Taking into consideration, perception of family relationship was evaluated by a qualitative question; it is necessary to conduct more studies focused on the use of instruments validated for the study population, which can evaluate other components involved in family relationship.

Conclusions

Psychological distress may be conditioned by psychosocial variables such as family, education and socioeconomic status. Therefore, it is important to analyze all those components, which characterize individuals, through a biopsychosocial approach, typical of family medicine and primary care.

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