Maternal mental health and social support: effect on childhood atopic and non-atopic asthma symptoms

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ABSTRACT

Background Atopic and non-atopic asthma have distinct risk factors and immunological mechanisms, and few studies differentiate between the impacts of psychosocial factors on the prevalence of these disease phenotypes. The authors aimed to identify whether the effect of maternal mental health on prevalence of asthma symptoms differs between atopic and non-atopic children, taking into account family social support.

Methods This is a cross-sectional study of 1013 children participating in the Social Change Allergy and Asthma in Latin America project. Psychosocial data were collected through a household survey utilising Self-Reporting Questionnaire and Medical Outcome Study Social Support Scale. Socioeconomic and wheezing information was obtained through the questionnaire of the International Study of Allergy and Asthma in Childhood, and level of allergen-specific IgE was measured to identify atopy. Polynomial logistic regression was used to estimate the association between maternal mental health, social support and atopic and non-atopic wheezing. Effect modification was evaluated through stratified polynomial regression according to social support level.

Results Maternal mental disorder had the same impact on atopic and non-atopic wheezing, even after adjusting for confounding variables. Affective, material and informational supports had protective effects on non-atopic wheezing. Effect modification was evaluated through stratified polynomial regression according to social support level.

Conclusion Poor maternal mental health is positively associated with wheezing, independent of whether asthma is atopic or non-atopic, but perception of high levels of social support appears to buffer this relationship in non-atopic wheezers only.

INTRODUCTION

Although atopic and non-atopic asthma manifest distinct risk factors and immunological mechanisms,¹–³ few studies examine the impact of psychosocial factors on each of these disease phenotypes. Furthermore, the majority of studies do not address the possible interaction between a number of psychosocial factors shared by both the mother and the asthmatic child within the family environment; this impedes a more robust understanding of the dynamics of the disease.

Living with care givers who have common mental disorders (CMD) is an important determinant of childhood asthma. Symptoms of anxiety, depression and maternal stress are associated with prevalence and severity of both asthma phenotypes and can alter the child’s immunological profile.⁹–¹⁰ Both asthma prevalence and maternal CMD are associated with the existence of family social support. It is assumed that social support increases the sense of parental self-efficacy and self-esteem, facilitates access to healthcare and increases instrumental and informational support, thereby enabling adequate management of the disease and preventing both the severity and the exacerbation of childhood asthma.¹¹–¹⁸ Family social support seems therefore to be an important potential moderator of the impact of maternal CMD on childhood asthma prevalence and morbidity.

We identified a gap in joint analysis of both the impact of maternal CMD and family social support on prevalence of childhood asthma, specifically of studies that examine the underlying mechanisms for the expression of these distinct disease profiles. The present study addresses this gap by investigating whether the effect of maternal CMD on prevalence of childhood asthma symptoms differs between atopic and non-atopic children in the presence of maternal social support.

METHODS

Study design

This is a cross-sectional analysis of a population cohort of children aged between 4 and 12 years old in the city of Salvador, Brazil, part of the Social Change Allergy and Asthma in Latin America (SCAALA) programme. Details of the study design and methods are presented elsewhere.¹²

Study population and sample

The SCAALA-Salvador project had 1445 children who were participants in a previous cohort study and had completed all follow-up data. These children were randomly selected from 20 000 residents of varying economic levels and environmental conditions.¹¹ The sample for this study comprised 1096 children whose questionnaires about mental health were answered by the child’s biological mother. From this sample, 1013 had complete data for all the covariates studied. Fifty-five questionnaires presented with missing data regarding social support, 24 regarding history of pneumonia and four regarding maternal level of education. In comparing the 83 subjects with missing data with the total sample, we noted that the prevalence of asthma symptoms was very similar (data not shown).

Instruments

An adapted questionnaire from the International Study of Allergy and Asthma in Childhood...
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(ISAAC)—Phase II was utilised to evaluate the prevalence of childhood asthma symptoms and to collect information about exposure factors. It is a standardised pre-coded and validated questionnaire, completed according to care giver reports about asthma and allergy symptoms, child’s health history and family socioeconomic level.

Blood samples were collected to assess allergen-specific IgE serum levels and were performed through radioimmunoassay (RAST) utilising commercial kits and the ELISA test, standardised in the group laboratory. Additional details have been published by Barreto et al.1

We used the Self Reporting Questionnaire (SRQ-20) to measure maternal mental health. This questionnaire was developed by WHO and has been validated for the Brazilian population.5 It is composed of 20 questions about the presence of depressive symptoms, dysthymia, phobia/anxiety, somatisation and neurasthenia. Brazilian studies indicate high sensitivity (85%) and specificity (80%) for this instrument when compared with psychiatric diagnostic interview.

A Social Support Scale was applied to the mothers; this had originally been developed for the Medical Outcomes Study (MOS). It is composed of 19 items with responses on a Likert scale that identify the frequency with which social support is perceived. The items were organised to cover five dimensions of social support: material, affective, positive social interaction, emotional and informational. The raw score was calculated for each dimension through the sum of points attributed to the items; the higher the score, the greater the perception of social support. For the purposes of analysis, the scores were dichotomised, using the first distribution quartile as a cut-off point. The scale has been adapted and validated in Brazil and presents high internal consistency levels and moderate item-scale correlation, enabling it to be used as a measure of perceived social support.

Outcome measures

Asthma symptoms were defined as the presence of wheezing in the last 12 months in association with at least one of the following conditions: having a medical diagnosis of asthma, difficulty talking due to wheezing, waking in the night at least once a week and wheezing after physical exercise.

Atopy was defined as the presence of a specific IgE for at least one of the most important aeroallergens (Dermatophagoides pteronyssinus, Blomia tropicalis, Blatella germanica, cat and dog). The cut-off point was 0.70 kU/L; a reliable value for detecting specific IgE through the RAST technique.

Individuals who presented with asthma symptoms in association with an IgE above 0.70 kU/L were classified as atopic wheezing (code 1). Those who presented with asthma symptoms but did not have a detectable IgE were classified as non-atopic wheezing (code 2).

Reference groups were coded as zero and chosen according to the impact on the outcome studied. We took individual characteristics as child’s sex, age and history of pneumonia. Maternal characteristics included perceived maternal mental health, maternal history of asthma, maternal school level and maternal membership of vulnerable families. The study included potential confounders that could influence the asthma outcomes, such as history of exposure to tobacco smoke, skin exposure to the mite D. pteronyssinus and parasitic infestations (Blomia tropicalis and Blatella germanica, the most prevalent in the city [80%] for this instrument when compared with psychiatric diagnostic interview.

Main exposure measures

Suspected maternal CMD was defined by eight or more positive responses to the SRQ-20, in line with previous studies involving Brazilian population.26 The variable was coded 0: not suspected and 1: suspected.

Covariates

Covariates were organised according to the impact on the outcome studied. We took individual characteristics as child’s sex, age and history of pneumonia. Maternal characteristics included perceived maternal mental health, maternal history of asthma, maternal school level and maternal membership of vulnerable families. The study included potential confounders that could influence the asthma outcomes, such as history of exposure to tobacco smoke, skin exposure to the mite D. pteronyssinus and parasitic infestations (Blomia tropicalis and Blatella germanica, the most prevalent in the city [80%] for this instrument when compared with psychiatric diagnostic interview.

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| Table 1 | Individual and family environment characteristics by suspected maternal CMD (N=1013) |
|---------|------------------------------------------------------------------------------------------|
|         | Suspected CMD (N=382)                                                                         | No suspected CMD (N=631) |
| Individual characteristics | | |
| Sex     | | |
| Male    | 200 (52.4) | 341 (54.0) |
| Female  | 182 (47.6) | 290 (46.0) |
| Age (years) | | |
| ≤7      | 244 (63.9) | 353 (55.9) |
| ≥8      | 138 (36.1) | 278 (44.1) |
| Atopic asthma symptoms | | |
| Yes     | 62 (16.2) | 69 (10.9) |
| No      | 249 (65.2) | 495 (78.4) |
| Non-atopic asthma symptoms | | |
| Yes     | 71 (18.6) | 67 (10.6) |
| No      | 249 (65.2) | 495 (78.4) |
| History of pneumonia | | |
| Yes     | 85 (22.3) | 97 (15.4) |
| No      | 297 (77.8) | 534 (84.6) |
| Material characteristics | | |
| History of asthma | | |
| High    | 233 (61.0) | 493 (78.1) |
| Low     | 149 (39.0) | 138 (21.9) |
| Material support | | |
| High    | 242 (63.4) | 468 (74.2) |
| Low     | 140 (36.6) | 163 (25.8) |
| Positive social interaction | | |
| High    | 225 (58.9) | 483 (76.5) |
| Low     | 147 (41.1) | 148 (23.5) |
| Emotional support | | |
| High    | 248 (64.9) | 503 (78.7) |
| Low     | 134 (35.1) | 128 (20.3) |
| Informational support | | |
| High    | 240 (62.8) | 469 (74.3) |
| Low     | 142 (37.2) | 162 (25.7) |
| Family income | | |
| <1 MW   | 225 (58.9) | 325 (51.5) |
| ≥1–<2 MW| 108 (28.3) | 200 (31.7) |
| ≥2 MW   | 49 (12.8) | 106 (16.8) |
| Family environment | | |
| Exposure to tobacco | | |
| Yes     | 119 (31.2) | 144 (22.8) |
| No      | 263 (68.8) | 487 (77.2) |
| Exposure to mould | | |
| Yes     | 257 (67.3) | 395 (62.6) |
| No      | 125 (32.7) | 236 (37.4) |
| Number of children | | |
| <2      | 234 (61.4) | 354 (56.2) |
| ≥2      | 147 (38.6) | 276 (43.8) |

CMD, common mental disorder.
included history of asthma, educational level, family income and affective, material, positive social interaction, emotional and informational social supports. We took family environmental characteristics as exposure to mould, exposure to tobacco and number of children.

Data analysis

Psychosocial questionnaires were administered at home by a team of one psychology co-ordinator and four supervised psychology students. This team was trained by a qualified professional and the students were constantly and directly supervised by a specialist. After coding, data were entered into the EPI INFO V6 by two different individuals, in order to reduce consistency errors. Then, the database was converted into STATA software program V.10.0, cleaned up and corrected for analysis.

Descriptive analysis was carried out to identify the prevalence of atopic and non-atopic asthma symptoms and to describe all the co-variables studied, according to suspected maternal CMD. We then estimated the non-adjusted OR through simple logistic polytomous regression, in order to identify associations between the covariates and atopic and non-atopic asthma symptoms. Those which demonstrated an association with at least one asthma outcome were inserted into a multiple logistic polytomous regression model to estimate the adjusted OR of association between maternal CMD, social support and child atopic and non-atopic asthma symptoms.1 27

We selected potentially confounding variables that were associated with exposure among those without the disease and, simultaneously, with the outcome among the non-exposed. After this, we utilised backwards multivariate logistic polytomous regression and considered presence of confounders when the measurement of association of the complete model and that of the reduced model differed by 10% or more. We also conducted the maximum likelihood test using the parameter \( \chi^2 \) with a p value \( \leq 0.05 \) to identify the best model. Some variables which were not confounder for the association between asthma symptoms and maternal CMD were kept in the model because they are usually referred to in the asthma literature.

To identify effect modification, we stratified the study population according to the variables of affective, material and informational social support and then conducted a multiple logistic polytomous regression to estimate the adjusted OR of association between maternal CMD and atopic and non-atopic wheezing. Effect modification was identified by the lack of overlap of ORs with strata-specific CIs.

The model’s goodness of fit was verified by deviance \( \chi^2 \) (256.17; p value =0.269), confirming that the model fitted well with the observed data. All the analyses were conducted using the STATA V.10 programme, except for the deviance calculation, for which we used the SPSS V.11.0 programme.

Ethical considerations

The study was approved by the National Ethics Committee in 2005, registration number 047-05/CEP-ISC FR-78169. Parents or guardians signed the Free and Informed Consent Form that contained detailed information about the research’s data collection procedures. Guardians were informed of results that suggested a need for medical/psychological care and were provided with relevant health service information.

RESULTS

Distribution of child sex was similar among mothers both with and without CMD symptoms. On the other hand, mothers with CMD symptoms had children who were mostly under 7 years old (63.9%) and the greatest prevalence of atopic (16.2%) and non-atopic (18.6%) asthma symptoms and a higher frequency of history of pneumonia (22.5%). Furthermore, they also presented a higher frequency of asthma history (17.6%) and less affective (61%) and material (63.4%) social supports, less positive social interaction (58.9%), emotional (64.9%) and

| Variables Co-variates | Atopic asthma symptoms (N = 131) | Non-atopic asthma symptoms (N = 138) |
|-----------------------|----------------------------------|------------------------------------|
|                       | Crude OR (95% CI) | Adjusted OR* (95% CI) | Crude OR (95% CI) | Adjusted OR* (95% CI) |
| Individual characteristics |                      |                                    |                    |
| Male sex | 0.80 (0.52 to 1.24) | – | 1.18 (0.61 to 1.72) | – |
| Age ≤7 years | 1.72 (1.11 to 2.66) | – | 2.13 (1.41 to 3.22) | – |
| History of pneumonia | 2.28 (1.38 to 3.78) | – | 2.14 (1.36 to 3.39) | – |
| Maternal characteristics |                      |                                    |                    |
| History of asthma | 3.70 (1.96 to 6.98) | – | 1.67 (1.02 to 2.76) | – |
| Primary level of education | 1.22 (0.89 to 1.78) | 2.02 (1.18 to 3.45) | – |
| More than primary level of education | 0.97 (0.59 to 1.59) | – | 1.46 (0.91 to 2.34) | – |
| Family income <1 MW | 1.05 (0.58 to 1.89) | – | 1.47 (0.81 to 2.67) | – |
| Family income ≥1-2 MW | 0.90 (0.48 to 1.71) | – | 1.17 (0.61 to 2.24) | – |
| Family environment |                      |                                    |                    |
| Exposure to tobacco | 1.16 (0.72 to 1.87) | 1.22 (0.80 to 1.85) | – |
| Exposure to mould | 1.29 (0.82 to 2.03) | – | 1.73 (1.14 to 2.63) | – |
| Number of children ≥2 | 1.23 (0.80 to 1.88) | – | 0.87 (0.59 to 1.27) | – |
| Psychosocial factors |                      |                                    |                    |
| Suspected CMD | 2.01 (1.31 to 3.11) | 1.74 (1.12 to 2.71) | 1.97 (1.35 to 2.86) | 1.73 (1.17 to 2.55) |
| High affective support | 0.82 (0.51 to 1.31) | 0.85 (0.52 to 1.37) | 0.65 (0.43 to 0.96) | 0.67 (0.45 to 1.01) |
| High material support | 0.76 (0.48 to 1.19) | 0.76 (0.48 to 1.20) | 0.64 (0.43 to 0.95) | 0.63 (0.42 to 0.95) |
| High positive social interaction | 0.98 (0.62 to 1.55) | 1.02 (0.64 to 1.63) | 0.69 (0.46 to 1.02) | 0.69 (0.46 to 1.03) |
| High emotional support | 0.76 (0.47 to 1.23) | 0.82 (0.50 to 1.35) | 0.83 (0.55 to 1.26) | 0.88 (0.57 to 1.34) |
| High informational support | 0.98 (0.61 to 1.56) | 0.96 (0.60 to 1.55) | 0.61 (0.41 to 0.90) | 0.60 (0.40 to 0.90) |

The bold values represent the statistically significant p values. *Adjusted for education, maternal history of asthma, exposure to mould, child’s age and history of pneumonia. CMD, common mental disorder.
Children under 7 years old, or with a history of pneumonia, or whose mothers presented with suspected CMD had a greater likelihood of atopic and non-atopic asthma symptoms. In contrast, affective, material, and informational supports demonstrated negative associations with non-atopic wheezing only, as well as with exposure to mould and maternal level of education. Furthermore, maternal history of asthma was associated with the occurrence of atopic and non-atopic asthma symptoms (table 2).

In the multivariate analysis, suspected maternal CMD was associated with atopic and non-atopic asthma symptoms when adjusted for education, maternal history of asthma, exposure to mould, child’s age and history of pneumonia. We maintained the same multivariate model to test association between social support and asthma symptoms, and we found that high material and informational supports were negatively associated with non-atopic wheezing.

To evaluate whether maternal asthma history and child’s age were confounding variables, we estimated their associations with suspected maternal CMD in the group of non-asthmatic children and simultaneously with atopic and non-atopic wheezing in the group of mothers with no CMD symptoms. Maternal history of asthma was a potential confounder since it increased the probability of CMD prevalence among mothers with non-asthmatic children and was also associated with atopic and non-atopic asthma symptoms in the group of mothers without CMD. Child’s age was not a confounding factor of the association between CMD and atopic and non-atopic asthma (table 3). Comparing the saturated and reduced models for maternal history of asthma, we observed a 7.5% increase of estimated OR between CMD and atopic asthma symptoms; it has been suggested that this is mediated by changes in certain inflammatory markers associated with the atopic and non-atopic profiles.9 10

We also identified the protective effect of material and informational social supports, a result that is consistent with previous findings in this area.10 20 It has recently been reported that high levels of social support received by the family reduced the risk of the child presenting with asthma by 34%.10 It has also been observed that low levels of family support are associated with an increase in asthma symptoms and with alterations in the pulmonary function of adolescents.5 19

In this study, the independent protective effect of social support was only found in non-atopic wheezing, supporting the hypothesis that the effects of psychosocial factors are more relevant to non-atopic asthma than to atopic asthma. Furthermore, our findings point to an intriguing possibility that the material and affective supports may act as a buffer for the impact of maternal mental disorder on non-atopic wheezing, although this was not statistically significant. This may be due to the reduced size of each stratum and the consequent reduction of the study power, as well as to the smaller size of the groups because of the two outcomes. However, it is also possible that social support does not function as a moderator of the impact of maternal CMD on non-atopic wheezing.

**DISCUSSION**

We found similar associations between suspected maternal CMD and asthma symptoms among atopic and non-atopic children. This finding is compatible with previous studies which have identified the contribution of maternal mental health to an increase in the prevalence of atopic and non-atopic wheezing in children.17

As maternal history of asthma is an important confounding factor in other asthma studies,2 4 7 we kept this variable in the model to estimate the association between maternal CMD and asthma symptoms. A robust association between maternal CMD and both asthma phenotypes examined here was maintained even after adjusting for this potential confounder, which indicates that the effect of maternal mental health on childhood wheezing is independent of the child’s exposure to the other biological or environmental risk factors studied in this project. This finding provides support to the hypotheses that the experience of chronic family stress affects the occurrence of asthma symptoms; it has been suggested that this is mediated by changes in certain inflammatory markers associated with the atopic and non-atopic profiles.9 10

Although there is a trend for ORs to be higher when the level of social support is lower, we did not find effect modification.

**Table 4** Effect modification for the association between suspected maternal CMD and prevalence of atopic and non-atopic wheezing by condition of exposure and outcome

| Affective support | Material support | Informational support |
|-------------------|-----------------|----------------------|
| Suspected CMD     |                 |                      |
| High, OR (95% CI) | Low, OR (95% CI)| High, OR (95% CI)   |
| 1.43 (0.87 to 2.35)| 2.21 (1.10 to 4.46)| 1.41 (0.85 to 2.33) |
|                   |                 |                      |
| CMD, common mental disorder.
atopic asthma and is a distal determinant of maternal mental health, acting in a chain of events related to the occurrence of the disease.

The mechanism of the action of social support on occurrence of maternal CMD and childhood asthma is not clear. Intervention studies have demonstrated that an increased perception of social support is associated with a reduction of maternal CMD and childhood asthma is not clear. Interventions established here. Although recent evidence from the literature corroborates the association in the direction presented here, new longitudinal studies are required in order to corroborate the hypotheses and findings presented. Furthermore, despite utilising validated questionnaires and broad support from the literature, the exposure and outcome measures may be subject to respondent bias since anxious/depressive parents (who also tend to be from families with lower incomes and probably have less access to healthcare) tend to report more asthma symptoms in their children and have a more pessimistic view of reality.16 17

Finally, these findings could have important implications for the implementation of public policies for the prevention and management of childhood asthma, by highlighting the importance of both maternal mental healthcare and the strengthening of social ties in order to promote the physical and psychological well-being of the child. Whether or not these factors are taken into consideration will either enhance or hinder efficiency in the care of asthma symptoms.

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Contributors LMDS was involved in data analysis and interpretation as well as in writing the first draft of the study. DNDs was involved in the study planning and design, data analysis and interpretation and helped to review the study draft. ICR was involved in the study planning and design, data interpretation and helped to review the study draft. MLB, principal investigator of the main study from which this present study was derived, was involved in the study planning and design, data interpretation and helped to review the study draft.

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