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USE OF SOCIAL SUPPORT AS PROTECTION AGAINST THE STRESS OF THE WORKING POOR

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Abstract

This article deals with the relationship between the stress and social support of the working poor. We assume that a person with low income is surrounded by a number of stressful events and could create more social networks and thus use social support more than a person who does not experience such situations.

The goal of this research was to find out whether social support of the working poor was so extensive that it could help in the protection against stress, which often arises due to a lack of finances.

This study was carried out in 2017 and at the beginning of 2018 in South Bohemia. It included 358 respondents whose income was at the minimum wage in 2017. We used the MOS and Holmes–Rahe Stress Inventory for social support standardized questionnaires. The data were statistically processed in the programme SPSS using correlations.

The results showed a large stress load with the risk of psychosomatic impacts and a low level of social support. The relationship between social support and the level of experienced stressful events was not confirmed. Although the working poor could use social support from the domain of *Love*, they do not. This article can positively affect the lack of data on the working poor.

Keywords: *Low income; Minimum wage; Poverty; Protective factors; Social support; Stress; Working poor*

ORIGINAL ARTICLE

INTRODUCTION

Although their number in the Czech Republic is one of the lowest in Europe, the working poor are beginning to be discussed These people have many problems that start with low-income stress. The goal of the research was to find out whether social support of the working poor was so extensive that it could help in the protection against stress, which often arises due to a lack of finances.

Theoretical basis

Currently, poverty and unemployment are one of the much-discussed topics. Fortunately, according to Sirovátka and Mareš (2006), the Czech Republic is one of the European countries with the lowest number of unemployed people and working poor.

It is more difficult to define this group of people than poverty. Poverty is a multidimensional and complex phenomenon (Alkire and Foster, 2011). According to the European Committee, a person is poor if their income and other resources are lower than the established standard. According to Eurostat, the established standard is 60% of the median income of the EU – and this line is the minimum acceptable standard of living (Statistics on Income,

2017). In 1990, the World Bank set the international poverty level to 1$ per day. In 2008, this was moved to 1.25$/day (Ravallion et al., 2009).

Today, there is much effort to define and classify poverty. It is all based on how poverty emerges. Goulden and D'Arcy (2014) state that poverty arises when a person is not capable of self-support or does not want to and cannot provide themselves with basic needs. In literature, we will often find poverty classified as objective and subjective.

Objective poverty is established by the law/state and clearly states what the term "satisfaction of basic human needs" means and what level it is at (most frequently, such poverty is established by the median percentage of income or subsistence income). Objective poverty can be divided into absolute and relative (Ravallion and Chen, 2011). Relative poverty focuses on income. In the Czech system, it is called social indigence (Kukla, 2016). Absolute poverty focuses on consumption. We can say that the bottom line here is subsistence income – the means that enable a person to satisfy only the most basic needs for survival. In the Czech system, this is called material needs (Kukla, 2016).

Subjective poverty is the assessment of one's own condition when a person says that they are in a state of poverty. It often does not correspond with objective poverty (Krebs et al., 2007).

There are groups of people who are threatened by poverty more than others. Such groups include single mothers, seniors, ethnic minorities and the relatively new group of the working poor (O'Doherty, 2017), which lately has become of larger interest to experts. The term – the working poor – already indicates that some working people (part-time or full-time) are still poor. Their incomes are mostly close to the minimum wage (Šustová, 2013).

There are a few definitions of the working poor. The first defines people who work but still live on the poverty line as the working poor (Baum, 2008). Another says that the working poor receive less than 60% of the median income of the given country. However, only the USA have an officially accepted definition of the working poor (Wójcik-Żołądek, 2013). It states that the working poor are people who spent at least 27 weeks in the labour force (that is, working or looking for work) but whose incomes still fell below the official poverty level. (A profile of the working poor, 2013).

Compared to the EU, the Czech Republic is in a better situation; only 4% of the working population are threatened by poverty (Wójcik-Żołądek (2013)).

Sirovátka and Mareš (2006) agree. According to them, up to now the Czech Republic does not include a large number of the working poor. However, Rychlíková and Bělíček (2017) claim that more than one-fifth of people in the Czech Republic worked for less than 83 CZK/hour in 2017, which is approximately 14,000 CZK/month (approximately 560 €). The average monthly salary in the same year was approximately 29,000 CZK (approximately 1,160 €).

According to Mareš (2006), stress from the fear of low income and the inability to pay for essentials is one of the greatest stresses. Dilmaghani (2017) adds that stress associated with insufficient finances is a strong predictor of worsened mental and physical condition.

In these stressful situations, it is very important for protective factors to work, which provide help and support in solving unpleasant and difficult situations (Šolcová and Kebza, 2003). Harmful effects of stress are decreased by social sources and various strategies for managing stressful situations. In this case, an individual can gain support from other people, groups and society, which can help them manage difficult situations better (Šolcová and Kebza, 1999). One of the protective factors is social support. It has been proven that social support is a good protective factor in unpleasant situations and improves a healthy life expectancy. This has been proven by many studies of various population groups (e.g. Berkmann and Glass, 2000; Gallant, 2003; Heaney and Israel, 2008; LaVeist et al., 1997).

Šolcová and Kebza (1999) described many models of using social support as a protective factor. As an example, we can use "the bumper model", which assumes that social support can help a person to be protected from the negative consequences of stress – it is a bumper. This model does not predict the relationship between social support and stress. Woodhead et al. (2014) studied the effect of social support in carers providing long-term health and social care. They experienced emotional

exertion, a high level of stress and showed a high level of burnout syndrome. According to this research, if the carers had the support of their supervisors, friends or family and they and their work were valued, this contributed highly to decreasing stress and the carers were much less emotionally exhausted.

Roohafza et al. (2016) studied the effect of social support and coping regarding neuroticism and stress management. It was shown that the gained social support decreased the growing cumulative effects of neuroticism and perceived stress, and increased the protective effect by decreasing the influence of the perceived stress.

The model of Šolcová and Kebza (1999) deals with the direct influence of social support. It assumes that social support has a direct protective influence on health and it is not important whether people are exposed to stress. Cohen et al. (2014) found out that the perceived social support and hugs from friends or family can directly have a positive effect on physical health. The respondents in this study were exposed to a virus that caused a cold. The infected participant who perceived him or herself to have a lot of social support and was hugged more often showed milder symptoms of the illness.

The study of Wiesmaierova et al. (2019), which included patients with acute coronary syndrome, showed that social support can decrease the negative effects of stress and influence the mental and physical wellbeing of cardiac patients. Patients with sufficient social support did not have symptoms of depression. On the contrary, patients with low social support had symptoms of depression and even a worsened renal function. According to Bakal (1992), people with a wide social network (friends, family, co-workers, people they know from interest associations etc.) are less likely to die young than people with a weak social network.

MATERIALS AND METHODS

We used the quantitative research strategy for this research (two standardized questionnaires). The first was the Holmes–Rahe Stress Inventory (HR), which contains a list of 43 stressful life events. The respondents tick the events that they experienced in the previous year. The resulting score is determined by adding up the points of all ticked events. The score shows the percentage of risk of weakened health due to the stress experienced in the previous two years (The American Institute of Stress, 2018). The second used standardized questionnaire was the Medical Outcomes Study – Social Support Survey (MOS). This questionnaire was created by the Rand and Medical Outcomes Study group. This tool should reflect individual social integration. If a person can create and maintain social relationships, they can use them to gain social support. The original 50 questions were reduced to 19 that cover the following domains of social support: tangible support, affectionate support, positive social interaction, and emotional/informational support. The respondents assess the support from the point of view of the length of its existence using the Likert five-point scale. The resulting total score is the value average of the domains (Kožený and Tišanská, 2003).

The sample group includes the working poor in South Bohemia. The condition for inclusion in the group was a minimum income during the collection of the data (10 220 CZK). The data were collected in 2017. We addressed the respondents at the job centre/employment service while they applied for state financial support. At the beginning of 2018, we used online questionnaires. After excluding the incorrectly completed questionnaires, the research included 358 respondents.

All respondents were informed that their answers and data would be used for the GAJU 037/2017/S research. We did not request their personal data.

The data were statistically analysed using the IBM SPSS Statistics 24 software. The reliability level was established to $\alpha = 95\%$. We used the correlation considering the type of variables.

RESULTS

The research included 225 women and 133 men: 52 respondents had basic education, 146 respondents were trained/had an apprenticeship, 125 had secondary education and 36 had university education.

Most respondents were between 36 and 45 ears old (121 respondents – 33.7%). 108 res-

pondents were between 46 and 55 years old (30.1%). 66 respondents were 35 and less (18.4%) and 63 respondents were 56 and older (17.8%).

The scores of the Holmes–Rahe are shown in Table 1. 130 (36.2%) respondents achieved a score of under 150 points, which means that the probability that their health will weaken is very low. 138 (38.4%) respondents achieved a score between 150 and 300 points, which means that there is a 50% chance for serious changes in their health condition in the next two years. 90 (25.1%) respondents achieved more than 300 points, which indicates an 80% risk of ill health in the next two years.

Table 1 – Groups of respondents by the achieved score

Score Holmes–Rahe (in points)		Numbers	Percentage
	under 150	130	36.2
	150–300	138	38.4
	over 300	90	25.1
	Total	358	99.7
Missing		1	0.3
Total		359	100.0

Source: GAJU 037/2017/S

We established the hypothesis that the level of social support positively affects the level of stressful life events. We tested the resulting scores of the HR and MOS questionnaire to verify it.

The achieved level of social support regarding gender was 17.21 for women and 17.33 for men. The total average score of the HR questionnaire for women was 206.84 and 220.95 for men. We first tested the relationship between the achieved score in the MOS-SSS and the HR questionnaires ($p = 0.610$, $r = -0.099$). We were then interested in the relationship between the individual domains in the MOS-SSS questionnaire and the achieved score in the HR questionnaire. To test this relationship, we used the Kendall's tau-b. The first tested domain was tangible support. The result of the test was $\tau_k = -0.063$ ($p = 0.087$). The second was affectionate support and the result was $\tau_k = -0.040$ ($p = 0.293$). The result regarding positive social interaction was $\tau_k = -0.018$ ($p = 0.634$) and regarding emotional/informational support was $\tau_k = -0.025$ ($p = 0.492$).

We also tested the relationship between the MOS-SSS total score and its domains and the individual groups in the HR questionnaire, which present a high risk of weakened health in a period of two years (Table 2). We first tested the total MOS-SSS score and the individual groups in the HR questionnaire. We achieved the coefficient of $\tau_k = -0.029$ ($p = 0.486$). We then tested *tangible support* ($\tau_k = -0.042$ ($p = 0.327$)), *affectionate support* ($\tau_k = -0.071$ ($p = 0.101$)), *positive social interaction* ($\tau_k = -0.024$ ($p = 0.572$) and *emotional/informational support* ($\tau_k = -0.020$ ($p = 0.626$)).

The results show that none of the tested relationships were statistically significant (Table 2). Regarding the sample group of the working poor, we did not confirm the influence of social support on the number of stressful experiences.

DISCUSSION

Unfortunately, we did not manage to find results in the Czech Republic to use as a comparative sample. Despite finding out that the MOS SSS 6 questionnaire was recently validated in Australia, it seems that the MOS has never been used abroad – regarding the working poor or even the poor (Holden et al., 2014). The MOS questionnaire is often used for studying social support in people with various health problems, which are mostly psychological. Compton et al. (2005) state that their research shows that lower level of social inclusion and social support increases the rel-

Table 2 – The correlation between the total HR and the MOS-SSS scores

Tested variables	*p*	r/τ_k*
Holmes–Rahe (total score) × MOS-SSS (total score)	0.610	$R = –0.099$
MOS-SSS – tangible support × Holmes–Rahe (total score)	0.087	$\tau_k = –0.063$
MOS-SSS – affectionate support × Holmes-Rahe (total score)	0.293	$\tau_k = –0.040$
MOS-SSS – positive social interaction × Holmes–Rahe (total score)	0.634	$\tau_k = –0.018$
MOS-SSS – emotional/informational support × Holmes–Rahe (total score)	0.492	$\tau_k = –0.025$
MOS-SSS (total score) × Holmes–Rahe (individual groups)	0.486	$\tau_k = –0.029$
MOS-SSS – tangible support × Holmes–Rahe (individual groups)	0.327	$\tau_k = –0.042$
MOS-SSS – affectionate support × Holmes–Rahe (individual groups)	0.101	$\tau_k = –0.071$
MOS-SSS – positive social interaction × Holmes–Rahe (individual groups)	0.572	$\tau_k = –0.024$
MOS-SSS – emotional/informational support × Holmes–Rahe (individual groups)	0.626	$\tau_k = –0.020$

* r = Pearson's correlation coefficient; τ_k = Kendall's correlation coefficient
Source: GAJU 037/2017/S

ative level of suicide attempts. The questionnaire has also been used for finding the level of social support regarding HIV patients in South Africa. Social support here is strongly associated with the number of relatives and close friends (Ncama et al., 2008). Our research showed that the respondents had a low level of social support and 6 respondents had the lowest possible score, which means almost no social support. We can say that the working poor still have some social support. Hwang et al. (2009) have similar claims regarding the homeless. This study confirms that social support in marginalized groups of people is still present, although not at the highest level. Another study in the African American population showed differences between men and women (Brown and Gary, 1987). The perceived social support along with the number of close relatives had a significant effect on the mental health of African American women but it was not shown in African American men. Our research did not show these differences.

Our research showed that in 38.4% of the respondents there was a possibility of serious changes in health condition in the next two years. In 50% of cases, the reason was low-income stress. 25.1% of the respondents had such a high score that there was an 80% risk of health failure in the next two years. 63.5% of the respondents showed a large possibility of negatively affecting their organism due to stress. Many studies have proven that stress due to low finances causes various health ailments. Wadsworth (2011) emphasizes the role of stress due to poverty in mental and physical problems. The problems include cardiovascular system ailments (Dimsdale, 2008; Steptoe and Kivimäki, 2012) or gastrointestinal system ailments (food intake) (Bhatia and Tandon, 2005; Nixon et al., 2011). Stress also causes sleep disorders (Han et al., 2012; Van Reeth et al., 2000).

Simmons and Swanberg (2009) clearly speak of stress affecting the work environment. We used other tools to gain information on the working poor, such as the National Study of the Changing Workforce. We found out that the working poor had depression and stress symptoms due to work uncertainty.

We also found out that the level of social support our respondents received was not associated with the level of experienced stressful events or Life Change Units (LCU) that cause a different stress level to every individual. If we focus on the "bumper model", which is mentioned by Šolcová and Kebza (1999), it is possible that a relatively low level of social support in our respondents does not protect them before the negative health impacts of the LCU.

CONCLUSIONS

Our research focused on the relationship between social support and stress in the working poor. We wanted to find out if their social sup-

port can help them with managing stressful events that they experience due to low income. We found out that the working poor experience many stressful situations that should be solved with various defense strategies because they can cause health failure. The second area of the research was focused on social support, which could be the right protection from the mentioned stressful situations. Unfortunately, we found out that the working poor do not have sufficient social support and their anticipated social support is not associated with the level of stress they experience. Although the working poor could use social support from the Love domain, this does not happen. We have not found many studies dealing with this issue – especially regarding the working poor. We hope that the number of studies dealing with this specific group will increase with the growing number of the working poor.

Conflict of interests

The authors have no conflict of interest to declare.

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