Social Support and its Association with Socio-demographic Characteristics, Dietary Patterns, and Perceived Academic Stress among College Students in Puerto Rico

Ideliz Pagán, MHSN; Carla Fabián, MHSN; Josué L. Ríos, MHSN;
Jesmari Betancourt, MHSN; Sonia Y. Cruz, MHSN, LND;
Anaisa M. González, MHSN, LND; Winna T. Rivera-Soto, PhD, LND

Objective: The objective of the present study was to determine the association between social support, dietary pattern, and academic stress among college students in Puerto Rico, based on their socio-demographic characteristics.

Methods: This was a retrospective, descriptive, epidemiological study that used a stratified sample of 275 college students. The data collection was done by means of a self-administered instrument.

Results: Most of the participating students were female (67.6%), ranged in age from 21 to 30 years (88%), and had health weights (56.4%); a large minority, 42.7%, lived in homes having low annual incomes. Most of the participating students perceived their academic loads as being heavy (68.2%) and their total academic stress levels as being moderate (60.7%). Most of the students had moderate levels of social support (61.5%). Social support was significantly associated with age (p = 0.04), in that young students had high levels of social support; with the school being attended (p = 0.01), in that students from the School of Dental Medicine had high levels of social support' and with perceived academic load (p = 0.02). Social support was significantly associated with age (p = 0.04), in that the younger students had higher levels of social support than did their older counterparts; with the school being attended (p = 0.01), in that students from the School of Medicine had higher levels of social support than did the students from the other schools; and with perceived academic load (p = 0.02).

Conclusion: There were associations between social support and age, school, and perceived academic load, but there were no such associations between social support and either level of academic stress or dietary pattern. [*P R Health Sci J 2013;3:146-153*]

Key words: Academic stress, Social support, Dietary patterns, Coping strategies

Stress is a common health problem in today's society (1, 2) and can be defined as a psycho-physiological process that is usually experienced as a negative emotional state (3). It is a common condition that is a response to a physical threat or to psychological distress and it generates a host of chemical and hormonal reactions in the body (4). Excessive stress may result in mental and/or physical problems and may diminish an individual's (in this case, the student's) sense of worth and might affect his/her academic achievements (5, 6). Some studies have classified stressors into 3 main categories: academic pressures, social issues, and financial problems (7). Stress is also defined as a particular relationship between the individual and his or her surroundings (8). When this relationship originates in an educational context, it is referred to as *academic stress* (9). Misra and Castillo state that stress is prevalent in students of all levels and all ages (10). Previous investigations have reported that students from the health

sciences have higher than normal stress manifestations (11). Academic stressors include a given student's perception of the extensive knowledge base required for them to be successful as students and beyond and the perception that there is inadequate time to develop such a base (12). These stressors may affect his/her learning ability, academic performance, and health (13). Some of the stressors in the academic environment are group competitiveness, work overload, an excess of responsibility,

a lack of incentive, and issues with professors and/or peers (14). In addition, past studies have suggested that exams, oral presentations, academic overload, lack of time to accomplish academic activities, compulsory assignments, and group work may be other factors in the generation of academic stress (15). Finally, others have also suggested that social and economic stressors (13), though external to the academic environment, can influence the levels of stress borne by students. Students experience physical and psychological reactions to stressors when they perceive excessive or negative stress (16). Excessive stress induces physical impairments such as persistent lack of energy, loss of appetite, headaches, and gastrointestinal problems (17). Methods that students utilize to reduce stress can include effective time management, the seeking out of social support, positive reappraisal, and engaging in leisure pursuits (18, 19).

Some of the coping strategies that are employed to deal with stress include the development of alternative behavioral, cognitive, and emotional responses that can be used to manage and tolerate stress, which strategies can further aid in reducing tension and restoring systemic equilibrium (8). The use of positive coping strategies can be a health protective factor, whereas a similar use of negative strategies can represent a health risk (1, 2). Negative stress-coping strategies such as consuming stimulating beverages or alcohol (or both) coupled with the general enervation that frequently accompanies stress can have a huge (primarily negative) impact on the lives of students suffering from stress. Similarly, the lack of social support, which supports is a significant focus of this study, must be taken into account when considering all of the factor that can negatively affect these students. Studies suggest that the aforementioned strategies and factor may also be linked to the alterations in diet that many university students experience's life (20, 21, 22, 23).

Social support has been defined as a social network's provision of psychological and material resources that are intended to aid individuals to cope with stress (24, 25). According to Gottlieb and Bergen, the term *social support* refers to those "resources that persons perceive to be available or that are actually provided to them by non-professionals in the context of both formal support groups and informal helping relationships" (26). This support can come from many different sources, such as an individual's spouse or lover, family, friends, co-workers, physician, or a community organization with which that individual is associated or to which he/she belongs (27). According to Sidney Cobb, "people with social support believe they are loved and cared for, esteemed and valued" (28), and part of a social network, "such as" and consists-in its totality-of the following: a family or community organization, that can provide goods, services, and mutual defense in times of need or danger (29). The literature describes a well-established relationship between social support and health, functioning, and quality of life (27). Social support is an important variable in the adoption and

maintenance of healthful dietary behaviours (30). It has also been associated with a number of health behaviors, including fruit and vegetable consumption (31, 32, 33), adherence to dietary change programs (34, 35), physical activity (36, 37), and smoking cessation (38, 39). The dietary patterns of an individual can be affected by the different coping strategies used to deal with academic stress since this kind of stress—as is the case of all kinds of stress—is associated with biological changes and alterations in food selection (40). Dietary patterns are those repeated practices (41) that comprise one's eating habits (42). Those patterns are consolidated as an individual develops, and depend on different factors, such as preferences, habits, prevailing customs, ways of living, food availability, financial circumstances, convenience, religion, and nutritional requirements (43). The objective of the present study was to determine the association between social support, dietary pattern, and academic stress among students in Puerto Rico, based on their socio-demographic characteristics.

Subjects and Methods

This was a retrospective, descriptive, epidemiological study. The study was approved by the Institutional Review Board (IRB) of the Medical Sciences Campus, University of Puerto Rico (UPR-MSC), protocol # A4540112.

Subjects

The research sample was proportionally stratified according to the different schools in the UPR-MSC system (comprising the Schools of Nursing, Pharmacy, Medicine, Dental Medicine, Public Health, and Health Professionals) and according to the registration lists provided by the Office of the Registrar. Stratification was performed by dividing the total population of each school by the overall population of students eligible for participation; this was done to obtain the proportion for each school. Then, that proportion was multiplied by the population of each school in order to obtain the total required sample size of each school. This procedure resulted in a sample of 252 students, with a distribution of 26 (14.7%) students from the School of Nursing, 7 (7.5%) from Pharmacy, 94 (35.4%) from Medicine, 10 (7.9%) from Dental Medicine, 41 (16.5%) from Health Professionals (SHP), and 74 (17.8%) from Public Health. The inclusion criteria of the study admitted into the study any student who had completed either his/her first or second year at UPR-MSC in the 2010-2011 academic period. Students who were in their third or fourth years, had been admitted with special permission, were enrolled in a joint program, were pregnant, or were under 21 years of age were excluded.

Methods

Subjects were recruited through e-mail, flyers posted around the campus, and direct contact. Those interested in participating

in the study were given an information sheet. After the potential participant had finished reading the information sheet to his or her satisfaction, the investigator explained the purpose of the study, the procedures that would be involved in its execution, the expected duration of the questionnaire, and the confidentiality of the entire process. The students who still wished to participate were given the questionnaire.

Instrument

Data were collected from the study participants, who answered the questionnaire in a private setting. The instrument used to collect the information of the present study was composed of 6 sections, which explored, among other factors, socio-demographic characteristics, academic course load, perceived academic stress, body composition, dietary patterns, and coping strategies. The instrument was developed for this study and validated by experts. Participants were asked to complete the questionnaire retrospectively, based on their experiences during the academic period covering from January to May 2011. The data were collected in August 2011.

Socio-demographic characteristics

The socio-demographic characteristics were limited to age, gender, and household income. Household income was classified as low, if it was from $0 to $24,999; moderate, if it was from $25,000 to $74,999 and high, if it was ≥$75,000.

Perceived academic load

Academic course load was assessed with a question eliciting the respondent's perception of his or her academic load and having the following response options: low, moderate, and high.

Perceived academic stress

Academic stress was assessed using a modified instrument (44) consisting of a 27-item Likert scale that explored the frequency with which each respondent experienced certain physiological, psychological, and behavioral responses to his/her academic environment; the items in the scale all had the same response options and corresponding values: Never (1), Rarely (2), Sometimes (3), Most of the time (4), and Always (5). The total score was arrived at by combining the individual scores from each of the 27 questions. Those with a total stress level of < 67 points were classified as having a low stress level, scores from 68 to 81 indicated a moderate stress level, and scores of > 82 indicated a high stress level. The internal consistency of the stress questionnaire was tested using Cronbach's alpha (0.895).

Physical activity

In the physical activity (PA) section, the questionnaire included a list of exercises that were categorized according to the type of activity (vigorous, moderate, light, or no activity), the frequency in which the exercises were done, and the total duration of each. Physical activity was used in the present report only to calculate the Total Energy Expenditure (TEE).

Body composition

For body composition, the students self-reported their height and weight. Body mass index (BMI) was then calculated with the following formula: BMI = weight $(kg)/[height (m)]^2$. The participants were categorized, according to the World Health Organization guidelines (45), as having a normal weight if their BMI was < 25 kg/m^2, as being overweight if their BMI was from 25.1 to 29.9 kg/m^2, and as being obese if their BMI was > 30 kg/m^2.

Dietary patterns

Dietary patterns (DP) were assessed using a quantitative food-frequency questionnaire (FFQ) that included an estimate of the number of meals consumed per day as well as the frequency and serving size of grains, vegetables, fruit, dairy products, meat and substitutes, oil, and water. The frequency of non-healthy snacks, soft drinks, and nutritional drinks was also taken into account. In order to analyze the results of the FFQ and determine the diet quality of each subject (using a modified Diet Quality Index [DQI]), the TEE was calculated based on gender, age, physical activity level, and body composition. The TEE consisted of Basal Metabolic Rate (BMR), Thermic Effect of Food (TEF), and PA. The BMR was calculated using the Mifflin-St. Jeor formula ([females] 10W + 6.25 H – 5A – 161; [males] 10W + 6.25 H – 5A + 5; where W = weight in kg, H = height in cm, and A = age). For both, men and women, we determined a kilocalories range of from 2000 to 2400 calories per day. However, the DQI is not able to distinguish when a given subject eats more or less of a particular food group than is recommended by the 2010 US Department of Agriculture Food Pattern (USDAFP-2010) (46). To determine food adequacy, we used the recommended kilocalories for each individual, employing the same TEE formula. We also considered the total number of meals per day and the consumption of non-healthy snacks as part of the DP category. To determine the DQI of our subjects, we modified a DQI questionnaire (47). We measured the following 3 primarily aspects: variety, adequacy, and moderation. The DQI represents a collection of scores applied to select dietary components to make up a total DQI score. Based on the total score, each individual was categorized as having either an "adequate" or "inadequate" dietary pattern. Scores for each component were totalled for each of the 3 main categories, and the scores for all 3 categories were tallied, resulting in the total DQI score (ranging from 0 to 65). Subjects who had a total score ranging from 33 to 65 points (> 50% of dietary recommendations) were classified as having an adequate DP (A-DP), whereas those who had a score of less than 33 points (<50% of dietary recommendations)

were classified as having an inadequate DP (I-DP). Variety in the diet was evaluated as overall variety. Inclusion of at least 1 serving of food per day from each of the 5 food groups (grains, vegetables, fruit, dairy, and meat) defined the maximum overall variety score. If the intake of any of these food groups was missing, the score was reduced from the perfect 15 by 3 points per each missing food group. Adequacy evaluates the intake of dietary elements that must be supplied sufficiently to guarantee a healthy diet. The scores for the 7 components in the category were assigned on the basis of the intake recommendation of each food group, depending on the mean kilocalorie of the total sample. The maximum score for adequacy was 41 points. A given participant received the highest score when he/she reached the intake recommendation for each food group. As the participant consumed less or more than what is recommended, the score decreased. Moderation evaluates the intake of foods that may need to be restricted, such as high-fat foods, non-healthy snacks, and soft drinks. In this category we established a maximum score of 9 points, with each component having a total point score of either 0 or 3. For fat moderation, an intake lower than or equal to 7 teaspoons per day was given the highest score of 3 points. In addition, scores for non-healthy snacks and soft drinks were based on frequency. Consumption of non-healthy snacks and/or soft drinks fewer than 1 time a week was considered to be reasonable or acceptable (48). The consumption of these foods less than 1 time/wk was given the highest score of 3 points. The TEF used was 10% (49) and the PA level was considered individually.

Coping strategies

The coping strategies that were assessed with the questionnaire were the following: using prescription drugs, drinking stimulating beverages, participating in physical activity, consuming alcohol, smoking, and the seeking of social support. The social support–seeking strategy for coping with stress will be evaluated in the present report only. Details and results relating to the other strategies are being published elsewhere. Social support was assessed using a 14-item instrument (Cronbach's alpha, 0.903) that utilized a Likert scale, with the options in each item ranging from never to always. For each item, the student had to answer based on whether the stress level posited in the given item had diminished (1 point subtracted), stayed the same (no change), or increased (1 point added) in moments of high stress. The total score was achieved by combining the scores from all of the statements, and subjects were classified as having a low (< 44 points), moderate (45-57 points), or high (>58 points) social support levels. This section also included 4 questions about with whom the participant lived and whether or not the participant received help with food preparation from that person.

Statistical methods

The descriptive statistics used to describe the demographic profiles, dietary patterns, and perceptions of academic stress (according to the participants' socio-demographic characteristics) were average, as were standard deviation for continuous variables and percentage distribution of frequency for categorical variables. Pearson's Chi-squared test (X^2) and Fisher's exact test were performed to assess the associations between social support, academic stress, and dietary patterns. All of the analyses were done using the Statistical Package for Social Sciences (SPSS) version 20.0. The statistical significance was defined as $p< 0.05$.

Results

The sample of this study consisted of 275 students, proportionally stratified among the 6 schools of UPR-MSC (Table 1). Most of the participating students were female (67.4%), were in the 21 to 30 year-old age group (88%), and had healthy weights (56.4%); a large minority, 42.7%, lived in homes having low incomes, and 36.1% were overweight or obese. Course load was perceived as being high by 68.2%, while total stress level was perceived by most as being moderate (60.7%) (Table 2). Chi-squared analyses were performed on the total stress level using tertiles because there were not enough students in the *high* category of total stress. Table 2 shows academic stress level and academic load, according to socio-demographic characteristic. There was a significant association between academic stress level and gender (p<0.001)—in that female students perceived their academic loads as being higher than did their male counterparts—and between academic load and school (p<0.001)—in that students from the School of Dental Medicine perceived their academic loads as being high, which the students from the other schools did not so perceive. Dietary patterns were analyzed by the socio-demographic characteristics of the participants (Table 3). No significant association was found. In general, most of the participants had inadequate dietary patterns (62.1%).

Social support level was analyzed by the socio-demographic characteristics of the participants (Table 4). Social support level was significantly associated with age, in that those who were ≤ 25 years of age tended to have moderate (41.5%) or high (10.9%) levels of social support, while those who were ≥ 26 years of age tended to have low (11.3%) levels of social support (p<0.05). No association was found between the level of social support and gender or income. There was an association between social support level and school, in that the School of Medicine had the highest proportion of students reporting receiving moderate or high levels of social support (p<0.05). There was an association between social support level and the perceived academic load, in that students reporting receiving low or moderate levels of social support also reported having heavy academic loads (14.2% and 41.6%, respectively) (p<0.05; Table 5). There was no association between level of social support and dietary pattern.

Table 1. Socio-demographic characteristics of the participants.

Variables	Classification	n	Percent
Age (y)	< 25	177	64.4
	>25	98	35.6
Total		**275**	
Gender	Male	89	32.4
	Female	186	67.6
Total		**275**	
School	Nursing	33	12.0
	Pharmacy	8	2.9
	Medicine	94	34.2
	Dental Medicine	15	5.5
	Health Professionals	46	16.7
	Public Health	79	28.7
Total		**275**	
Annual Household Income	Low	117	42.7
	Moderate	101	36.8
	High	56	20.4
Total		**274**	

Table 2. Academic stress level and academic load in the sample, according to socio-demographic characteristic.

Socio-demographic characteristics	Academic stress level % (n)			Academic load % (n)	
	Low	Moderate	High	Moderate	Heavy
Age (y)					
<25	22.9 (63)	40.4 (111)	1.1 (3)	16.8 (46)	47.4 (130)
>25	14.2 (39)	20.4 (56)	1.1 (3)	15.0 (41)	20.8 (57)
Total % (n)	**37.1 (102)**	**60.7 (167)**	**2.2 (6)**	**31.8 (87)**	**68.2 (187)**
Gender					
Male	17.1 (47)	15.3 (42)	0.0 (0)	8.0 (22)	24.0 (66)
Female	20.0 (55)	45.5 (125)	2.2 (6)*	23.6 (65)	44.0 (121)
Total % (n)	**37.1 (102)**	**60.7 (167)**	**2.2 (6)**	**31.8 (87)**	**68.2 (187)**
Household Income					
Low	14.6 (40)	27.0 (74)	1.1 (3)	14.6 (40)	28.1 (77)
Moderate	14.6 (40)	21.9 (60)	0.4 (1)	14.2 (39)	22.6 (62)
High	8.0 (22)	11.7 (32)	0.7 (2)	2.9 (8)	17.5 (48)
Total % (n)	**37.2 (102)**	**60.6 (166)**	**2.2 (6)**	**31.8 (87)**	**68.2 (187)**
School					
Nursing	5.1 (14)	6.9 (19)	0.0 (0)	5.5 (15)	6.5 (18)
Pharmacy	1.8 (5)	1.1 (3)	0.0 (0)	1.1 (3)	1.8 (5)
Medicine	10.5 (29)	21.8 (60)	1.8 (5)	1.5 (4)	32.4 (89)*
Dental Medicine	1.5 (4)	4.0 (11)	0.0 (0)	0.0 (0)	5.5 (15)
Health Professions	5.5 (15)	11.3 (31)	0.0 (0)	6.5 (18)	10.2 (28)
Public Health	12.7 (35)	15.6 (43)	0.4 (1)	17.1 (47)	11.6 (32)
Total % (n)	**37.1 (102)**	**60.7 (167)**	**2.2 (6)**	**31.8 (87)**	**68.2 (187)**

*Statistically significant association by Chi² (p<0.05).

Data drawn from the social support section of the questionnaire, show that 55.3% of the participants reported that they lived with one or more family members, 22.2% lived with someone else, and 19.6% lived alone. In addition, we found an association between social support level and not having to prepare one's own food (that is, some respondents reported that another person prepared food for him or her on a regular basis) (p<0.05). Of the sample members, 58.2% reported that someone usually prepared their food. Of these, 55.3% answered that not having to prepare their own food in high-stress moments was helpful. Also, 46.9% of the ones who had help with food preparation (or who did not prepare their food at all) considered that they were eating well, and 38.8% who received such help (or the alternate) considered that they were eating very well.

Of the coping strategies explored in the present study, the seeking of social support was the most common (34.3%). In addition, 69.5% of the students reported that the seeking of social support as a coping strategy was effective, and 77.5% confirmed that they would use this strategy again in the future. Furthermore, the social support level that the respondents felt during moments of high stress was reported by most as being moderate (61.5%).

Table 3. Association between dietary pattern and socio-demographic characteristic in the sample.

Socio-demographic characteristics	Dietary Pattern % (n)		Chi² Significance (p<0.05)
	Inadequate	Adequate	
Ages (y)			
<25	41.7 (110)	22.3 (59)	0.255
>25	20.5 (54)	15.5 (41)	
Gender			
Male	18.2 (48)	13.6 (36)	0.185
Female	43.9 (116)	24.2 (64)	
Household income			
Low	25.1 (66)	18.3 (48)	
Moderate	25.1 (66)	12.2 (32)	0.366
High	12.2 (32)	7.2 (19)	
School			
Nursing	8.3 (22)	3.8 (10)	
Pharmacy	3.0 (8)	0.0 (0)	
Medicine	18.9 (50)	13.3 (35)	
Dental Medicine	4.5 (12)	1.1 (3)	0.098
Health Professions	10.6 (28)	6.4 (17)	
Public Health	16.7 (44)	13.3 (35)	
Total % (n)	**62.1 (164)**	**37.9 (100)**	

Discussion

Previous investigations have found that students in the health sciences usually have high academic stress levels (11). In the present study, we found that most had moderate total stress levels and heavy academic loads. This is consistent with the literature. We did not find an association between age or income level and

total stress level, but we did find a significant difference between academic stress level and gender, in that females tended to have higher levels of this kind of stress, than did men. This difference may be the result of society's perception and expectations of females. As revealed in the literature, female students more often report letting out their feelings; most women also tend to exhibit stress more overtly than males do (10).

Table 4. Association between socio-demographic characteristic and social support level.

Socio-demographic characteristics	Social Support Level % (n)			Chi² significance (p<0.05)
Ages (y)	*Low*	*Moderate*	*High*	
<25	12.0 (33)	41.5 (114)	10.9 (30)	0.040*
>25	11.3 (31)	20.0 (55)	4.4 (12)	
Gender				
Male	9.1 (25)	18.2 (50)	5.1 (14)	0.053
Female	14.2 (39)	43.3 (119)	10.2 (28)	
Total % (n)	**23.3 (64)**	**61.5 (169)**	**15.3 (42)**	
Household income				
Low	10.9 (30)	25.5 (70)	6.2 (17)	
Moderate	9.5 (26)	22.3 (61)	5.1 (14)	0.144
High	2.9 (8)	13.5 (37)	4.0 (11)	
Total % (n)	**23.4 (64)**	**61.3 (168)**	**15.3 (42)**	
School				
Nursing	2.9 (8)	8.4 (23)	0.7 (2)	
Pharmacy	1.5 (4)	0.7 (2)	0.7 (2)	
Medicine	6.9 (19)	20.7 (57)	6.6 (18)	0.0012*
Dental Medicine	0.0 (0)	4.0 (11)	1.5 (4)	
Health Professions	4.0 (11)	9.8 (27)	2.9 (8)	
Public Health	8.0 (22)	17.8 (49)	2.9 (8)	
Total % (n)	**23.4 (64)**	**61.5 (169)**	**15.3 (42)**	

Table 5. Association between social support level and academic load.

Academic Load	Social support level % (n)			Chi² Significance (p<0.05)
	Low	Moderate	High	
Moderate	9.1 (25)	19.7 (54)	2.9 (8)	0.016*
Heavy	14.2 (39)	41.6 (114)	12.4 (34)	
Total % (n)	**23.4 (64)**	**61.3 (168)**	**15.3 (42)**	

The present study also found a significant association between social support and age, in that young students had higher levels of support than did their older counterparts. We also found a significant association between social support and the school being attended, in that students from the School of Medicine had higher levels of such support than the students who attended any of the other 5 schools did. No studies were found that supported either of the aforementioned findings. We also found a significant association between social support and self-perceived academic load, in that those with greater than normal loads also had greater support in that those participants

with heavy academic loads tended to receive the most social support. However, no association was found with total stress levels. This difference may be attributed to the fact that stress level was assessed with a 27-item questionnaire, whereas perceived academic load was assessed with a single question, which question did not take into account other factors. Our results are not supported by any evidence that could be found in the literature.

Even though there was not a significant association between social support and household income, it is important to mention that 42.9% of the students who were in the high category of social support lived in households with high annual household incomes. There is evidence that social support varies by social class and is greater in higher social groups (50, 51).

The majority of the participants reported that they lived with someone, which might suggest the presence of social support. On the other hand, it is important to remember that 19.6% of the students lived alone, which could have been a factor affecting the social support they received during the academic period covered by the study. The literature states that social support comes from an individual's spouse or lover, family, friends, co-workers, physician, associated community organization(s), or some combination of any or all of the previous (27). Even though 46.9% and 38.8% of the participants who received help with food preparation believe they are eating well and eating excellently, respectively, 62.1% of the sample had inadequate dietary patterns. This suggests that the respondents may associate the help they receive with good dietary patterns or that they have an inaccurate perception of what healthy eating is.

Several limitations were inherent to the study design. The data collection was performed in August 2011, while the scope of the questions was limited to the academic period covering from January to May 2011; therefore, there may have been some recall bias. Also, the questionnaire was extensive, possibly resulting in random answers. On the other hand, the study performed included a representative sample of the UPR-MSC student body. Furthermore, it is the first study in Puerto Rico that has attempted to measure the associations between social support level, academic stress level, and dietary patterns.

In conclusion, there is an association between social support and age and between school being attended and perceived academic load, but there is no association between social support and academic stress or between social support and dietary patterns. The coping strategy used most by the participating students was that of seeking social support. Most of the participants reported that the strategy was effective and that they would use it again.

Resumen

Objetivo: El objetivo del presente estudio fue determinar la asociación entre el apoyo social, patrones alimentarios y

estrés académico entre estudiantes universitarios en Puerto Rico según sus características socio-demográficas. Métodos: El estudio realizado fue epidemiológico descriptivo retrospectivo en una muestra estratificada de 275 estudiantes universitarios. La recolección de datos se llevó a cabo con un instrumento auto-administrado. Resultados: La mayor parte de los estudiantes que participaron fueron féminas (67.6%), 21 a 30 años de edad (88%) y con peso saludable (56.4%); la gran minoría, 42.7%, vivía en hogares con un bajo ingreso. La mayor parte de los estudiantes percibieron su carga académica como fuerte (68.2%) y su estrés académico total en un nivel moderado (60.7%). La mayor parte de los estudiantes obtuvieron un nivel moderado de apoyo social (61.5%). Hubo una asociación significativa entre el apoyo social con edad (p = 0.04), donde estudiantes de menor edad tuvieron niveles más altos de apoyo social, con escuela (p = 0.01), donde aquellos estudiantes de la Escuela de Medicina Dental tuvieron niveles más altos de apoyo social, y con carga académica percibida (p = 0.02). Conclusión: Se encontró una asociación entre el apoyo social y edad, escuela y carga académica percibida, pero no con estrés académico o patrones alimentarios.

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