

Perceived Social Support and Its Relationship to Mental Health among Unmarried Women of Delayed Marriage Age: A Correlational–Comparative Field Study in Algiers Province

Latifa HADJ-LAKEHAL^{1*}

Academic Status : Doctoral Student in Doctorat ès Sciences – Clinical Psychology

Department : Department of Psychology

University : University of Algiers 2 Abou El Kacem Saâdallah, Faculty of Social Sciences, Algeria

Email : latipsy@hotmail.fr

Received: 05/02/2026

Accepted: 15/07/2026

Published: 22/07/2026

Abstract

The present study examined the relationship between perceived social support and mental health among unmarried women of delayed marriage age in Algiers Province, and tested differences in mental health by employment status and educational level. A descriptive correlational–comparative design was adopted. Data were collected through a Google Forms questionnaire using snowball sampling, a procedure justified by the sensitivity of the target group and the absence of an official sampling frame. The final sample comprised 78 women aged 35–52 years ($M = 39.74$; $SD = 4.12$), including 41 employed and 37 non-employed participants. Instruments were an adapted 56-item mental-health scale originally developed by Salah Fouad Makkawi (2002) and a 24-item adapted perceived social support scale (TPO) covering family, friends/peers, and social–religious support. Analyses were performed with SPSS 26 (descriptive statistics, Pearson r , independent-samples t -test, and one-way ANOVA with Scheffé post hoc comparisons). Mental health was moderate-to-high ($M = 121.34$; $SD = 18.41$) and perceived support was moderately high ($M = 55.21 / 72$). A significant positive correlation emerged between total support and total mental health ($r = .61$, $p < .001$). Family support was the strongest correlate ($r = .58$), followed by social–religious support ($r = .52$) and friends' support ($r = .47$). Employed women scored significantly higher on mental health ($t = 4.18$, $p < .001$). Differences by education favored university graduates. Findings are discussed through the buffering model of social support and the cultural stigma attached to delayed marriage in Algeria.

Keywords: perceived social support; mental health; delayed marriage; Algerian unmarried women; Algiers Province.

First: Introduction

Since independence, Algerian society has witnessed rapid socio-demographic and economic transformations that have reshaped the family life cycle and the age of entry into the marital bond. The average age of first marriage among females has risen steadily, and has moved from the common pattern of early marriage in the first decades after independence to a pattern in which marriage is delayed until after the mid-thirties among large segments of educated urban women. Official data show an increase in the percentage of unmarried women in the age group of 30-49 years, making delaying the age of marriage an extended social reality and not an occasional individual incident (Karkouch and Shradi, 2014).

This transformation cannot be understood in isolation from the generalization of female education, women's entry into the labor market, the rising cost of establishing independent housing, and the changing criteria for choosing a partner (Mathar, 2007). However, the cultural structure did not fully keep pace with this structural transformation. In the Maghreb social imagination, marriage is still a central criterion for the completion of the social status of adult women (Botvanusht, 1984; Toualbi, 1984).

Then the situation of a girl who is late for marriage turns into a stressful situation that may be associated with a double stigma: the stigma of inferiority in the eyes of some of those around her, and the stigma of pity that may empty professional and educational achievement of its symbolic significance. Various Algerian and Arab studies have documented the repercussions of this situation on self-esteem, future anxiety, depressive response, and psychological security (Zargui, 2019; Blairdouh, 2021). However, most of these works focused on negative symptoms without devoting sufficient space to psychological prevention mechanisms, most notably perceived social support as a resource that can reduce the impact of stigma and nurture a sense of meaning and belonging.

Formulate the research problem

The problem stems from a clinical and field observation that girls who are late for marriage are not a homogeneous group in suffering. Some of them show cohesion and steadfastness, while others suffer from chronic anxiety, disguised sadness, and a feeling of emotional emptiness despite apparent successes. The difference, according to a number of models in clinical psychology, is not only due to personality traits, but also to the quality of the perceived social network: Does the girl find unconditional family support? Does she have female friends who do not reduce her marital status to her? Does her religious and social environment give her a discourse that alleviates blame and redefines human value outside the "married/unmarried" binary?

In the buffering model, perceived social support is viewed as a resource that mitigates the psychological impact of chronic stress, not simply by having people around the individual, but by realizing that these people are available, understanding, and unconditional (Cohen & Wills, 1985). In the context of the delay in Algerian marriage, this awareness is particularly important because the source of pressure is essentially social: looks, hints, repeated questions on occasions, and explicit or implicit comparison with married female peers.

Hence, the problem of the study is formulated as follows: If delaying the age of marriage is a chronic stressful situation in the Algerian context, is the increase in perceived social support associated with an increase in psychological health among the girls concerned? Does this health vary depending on professional integration and educational level, as they are potential sources of a parallel support network and symbolic and economic independence?

Study questions

The main question: Is there a statistically significant correlation between perceived social support and mental health among girls who are late for marriage in the state of Algeria?

Sub-questions:

1. Is there a significant relationship between the dimensions of perceived social support (family, friends and colleagues, social and religious environment) and the overall degree of mental health?
2. Are there statistically significant differences in the level of mental health attributable to the work variable (working/staying at home)?

3. Are there statistically significant differences in the level of mental health attributable to the educational level variable?
4. What is the level of perceived social support and psychological health among the sample members?

Study hypotheses

General hypothesis: There is a positive, statistically significant correlation between perceived social support and mental health among girls who are late in marriage.

The first hypothesis: There is a significant positive relationship between each dimension of perceived social support and the overall degree of mental health.

The second hypothesis: There are significant differences in mental health in favor of working girls compared to those who stay at home.

Third hypothesis: There are significant differences in mental health attributable to educational level in favor of higher levels.

Objectives of the study and its importance

The study aims to measure the level of the two variables in the sample, test the correlation between them at the overall and dimensional levels, examine differences according to work and education, and extract implications that can be used in family and clinical counselling. As for the theoretical importance, it is represented in enriching the Algerian psychological library with a field study that explicitly links a preventive resource (perceived support) and a comprehensive consensus indicator (mental health) among a group that has rarely been studied using locally adapted tools. As for the practical importance, it is represented in directing psychological accompaniment programs away from the discourse of reducing intervention to “solving the marriage issue,” towards strengthening supportive networks and modifying the family discourse associated with stigma, and in providing specialists with two modified scales that can be used in the clinic and research.

Procedural definition of concepts

Perceived social support: the degree obtained by the participant on the modified TPO scale (24 items, three-dimensional scale), with its three dimensions: family support, support from friends and colleagues, and support from the social and religious environment. The total score ranges from 24 to 72, with a higher score indicating a stronger perception of the availability of support.

Mental health: the total score on the Salah Fouad Makkawi scale, modified and adapted for girls who are late for marriage (56 items, triple scale after reversing the negative items). The score ranges from 56 to 168. Interpreted as follows: 56–93 low; 94–131 average; 132–168 high. It should be noted that the scale provides a composite index of psychosocial adjustment, and does not cover all dimensions of mental health in the clinical, diagnostic sense.

A girl who is late for marriage: procedurally, every woman who is never married, residing in the state of Algeria, and who is 35 years of age or older at the time of the answer, regardless of her professional status or educational level.

Second: The theoretical framework and previous studies

1. .Perceived social support

1.1. .Concept

The psychological literature distinguishes between received social support (the help that is actually provided) and perceived social support (the individual's belief that help is available if he or she needs it). Cognition, rather than objective network size, has been shown to be the strongest

predictor of psychological health and adaptation to stress (Zimet et al., 1988; Qanun, 2016). An individual may be surrounded by many people without feeling that they understand him or stand with him without blame. His numerical network may narrow and his perception of support remains high if there are one or two emotionally stable people.

In this study, perceived support is defined as the girl's self-evaluation of the availability of emotional, functional, and informational support from family, friends, and the social and religious environment, including the feeling that she is not ostracized in gatherings, and that marriage is interpreted as a division and a share, not a personal accusation.

1.2. Sources and models

There are many sources of support: the nuclear and extended family, peers and co-workers, and the symbolic group (neighbors, family elders, religious discourse). The religious dimension occupies a special place in the Algerian context as a framework of meaning that re-arranges events according to fate and destiny, and reduces the interpretation of delay as a personal failure (Kandil, 2025).

As for the explanatory models, the most prominent are two models: the Main Effect model, which assumes that support benefits health whether there is stress or not; The buffering model assumes that the benefit of support appears primarily when pressure rises, as it prevents the stressful event from turning into a disturbance (Cohen & Wills, 1985). The situation of delayed marriage is closer to chronic, ongoing stress than to an acute event, which makes both models valid: support nurtures appreciation on a daily basis, and may mitigate the impact of peak moments (wedding events, questions from relatives, passing a new year without an engagement).

1.3. Support in local studies on compressive samples

Qanoun's (2016) study on patients with viral hepatitis in Batna showed a negative association between perceived support (Zimmit scale) and depression (Beck), without sex differences. Dalal (2022) found in a path analysis model among parents of children with chronic diseases that stress directly reduces life satisfaction, and that dimensions of support (family, friends, special people) directly raise satisfaction. As for Al-Saadi (2021), she demonstrated the predictive ability of support in psychological immunity among refugee women in the Jenin camp. These results point in one direction: awareness of the bond is a transient resource for sickness, displacement, and stressful family contexts.

2. Mental health and late marriage

2.1. The approved concept of mental health

Mental health in this study is not reduced to the absence of a clinical diagnosis, but rather to the girl's ability to be satisfied with herself, to bear pressures without functional collapse, to have a sense of meaning, to maintain relationships, and to commit to values and religion if she chooses, while acknowledging the presence of sadness or anxiety without it swallowing up the identity entirely. This perception is consistent with the structure of the modified Makkawi scale, which collects positive items (satisfaction, meaning, religiosity, productivity) and negative items (insomnia, self-blame, emotional emptiness, fear of loneliness and need, parasomatic symptoms). Accordingly, the scale covers a general indicator of psychosocial adjustment related to the situation of delayed marriage, and does not claim to measure all components of mental health according to World Health Organization classifications or specialized clinical scales (depression, pathological anxiety, psychotic disorders).

2.2. Delayed marriage as a psychosocial pressure

Algerian studies indicate that social discourse still links women's value to marriage and childbearing, even when they reach prestigious professional positions. Botfnousht believes that the self-esteem of Algerian women remains symbolically linked to childbearing, and that an unmarried girl may be perceived as incomplete unless she achieves this horizon (Aurda Zargui, 2019). Case studies on arrears in marriage show fluctuating self-esteem, relative isolation, and the internalization of a view of failure even when there is academic or professional success (Zarqi, 2019).

In a comparative direction, Zatoto (D.T.) found that unmarried women had a higher depressive response and higher vague thinking compared to married women, with a positive correlation between depression and vague thinking. Blairdouh (2021) linked optimism and pessimism to future anxiety among 272 women who were late for marriage. As for Qandil (2025), she tested the mediating role of perceived support between cognitive distortions and suicidal ideation among adolescents. This result, although different in its sample size, supports the logic of the current study: cognitive distortion ("I am incomplete because I am not married") does not automatically turn into a collapse if there is perceived support that corrects the meaning.

Structural family dimensions are not absent: Studies of the perceived family structure have linked suicide attempts among some latecomers to the quality of relationships within the home, not to lateness alone. Other studies have also linked delaying marriage to psychological security and the mental health of girls in the states of Chlef and Tissemsilt, and to the phenomenon's impact on working women in Skikda (Obaid and Laitem, 2020). The bottom line is that suffering is not an inevitable fate of delay, but rather is mediated by the quality of family discourse, opportunities for independence, and resources for meaning.

2.3. Work and education as modifying contexts

Work provides income, routine, colleagues, an alternative identity to marital identity, and reduces hours of direct exposure to domestic questions. Higher education expands the cognitive horizon and reinterprets "female success." Therefore, the study assumes a relative superiority for female workers and those with a university level, without this meaning that those who stay at home are doomed to suffering if they have warm family support and a supportive religious discourse.

3. Previous studies and comments

The literature can be classified into three groups: (a) Algerian and Arab studies on the sociology of delayed marriage and its economic and educational causes (Karkouch and Chradi, 2014); (b) Psychological studies of symptoms among late marriages: self-esteem, depression, future anxiety, optimism and pessimism, psychological security, and mental health (Zarqi, 2019; Zatoto, D.T.; Blairdouh, 2021; Obaid and Laitem, 2020); (c) Studies of perceived support in other stressful contexts (Qanoon, 2016; Dalal, 2022; Al-Saadi, 2021; Qandil, 2025).

It is noted that there are few studies that explicitly combine a multidimensional perceived support scale with a mental health scale specifically adapted for girls over thirty-five in the state of Algeria, with a correlational and comparative statistical treatment at the same time. It is also noted that many of the works relied on very small samples (case studies) or samples of different contexts (patients, refugees, adolescents). Hence, the addition of the current study is determined: a field sample of 78

urban participants, two adapted tools with documentation of modification procedures, documented electronic collection, and SPSS analysis that covers both the relationship and the differences.

Third: Methodology and procedures of the field study

1. Study methodology

The descriptive analytical approach was adopted in both its correlational and comparative parts: correlational to examine the relationship between two related quantitative variables (perceived social support and mental health), and comparative to examine actual differences in mental health according to work (t-test for two independent samples) and educational level (one-way analysis of variance). The study does not claim experimental causality, but rather detects a correlational and comparative pattern that is open to theoretical interpretation in light of the protective barrier model.

2. Research population and sample

The theoretical population consists of unmarried women aged 35 years and over residing in the state of Algiers (central Algiers and the urban suburbs: Bir Mourad Rais, El Harrach, Bab Ezzouar, Casablanca, El Biar, Bouzareah, and others). A formal sampling frame could not be assigned to this group due to the absence of comprehensive institutional records and the social sensitivity of the topic; Therefore, non-probabilistic snowball sampling was used, which is a method suitable for hard-to-reach groups.

The questionnaire was designed on Google Forms and included an informed consent page, demographic data, a mental health scale (56 items), and a support scale (24 items). The link was sent through professional and women's networks and groups of female university graduates in the capital, with a request to be redirected to acquaintances who met the age and marital status requirements. The link was open for five weeks. The number of initial responses was 91, of which 13 responses were excluded (age less than 35, previous marriage not initially declared, or missing questionnaires by more than 10%). The final sample settled at 78 complete cases.

Table (1): Demographic characteristics of the final sample (n = 78)

variable	category	Frequency	Percentage%
Work	A worker	41	52.6
Work	Staying at home	37	47.4
Educational level	Secondary or less	19	24.4
Educational level	University (Bachelor/Master)	46	59.0
Educational level	Postgraduate studies	13	16.7
Age	35–39 years	44	56.4
Age	40–44 years	23	29.5
Age	45 years and over	11	14.1
Housing	With the original family	61	78.2
Housing	Independent	17	21.8

The average age was 39.74 years with a standard deviation of 4.12. The predominance of living with the original family indicates that most of the participants are still in the domestic space, from which a large part of the pressure and support stems.

3. Measurement tools and their psychometric properties

3.1 Revised Mental Health Scale (56 items)

The original is Salah Fouad Muhammad Makkawi's (2002) mental health scale for students, which consists of 56 items on a three-tiered scale. It was re-adapted to fit the characteristics of post-marriageable girls, keeping the same number of items and the logic of positive and negative items. The adapted scale covers five content areas - not factors extracted globally in this study - which are: A. Self-satisfaction and personal meaning (positive items related to life value and problem-solving ability).

for. Social relations and perceived acceptance (satisfaction with the treatment of others, acceptance of the environment).

C. Negative emotional and physical symptoms (insomnia, hopelessness, perceived psychological problems, somatic complaints).

D. Stress related to marital status and stigma (pity looks, fear of loneliness as one ages, emotional emptiness despite achievement, family pressure around marriage).

e. Valuable and practical resources (religious meaning, financial independence, productivity).

Accordingly, the scale provides a composite overall score for psychosocial adjustment in this context, and is not used as a substitute for specialized clinical diagnostic tools.

Correction: Positive items (24 items) are corrected 3-2-1, and negative items (32 items) are corrected 1-2-3. Overall range 56–168. Levels: Low 56–93; median 94–131; High 132–168.

3.2 Honesty of arbitrators and amendment procedures

The modified image was presented to five specialized arbitrators: three in clinical psychology and two in psychometrics, from the universities of Tissemsilt and Blida 2. Each arbitrator was asked to rate each item in terms of: (1) the suitability of the content to the procedural definition of mental health in girls who are late for marriage; (2) Clarity of linguistic formulation; (3) Absence of language that blames or encourages marriage. A threshold of agreement of 80% or more (i.e. agreement of at least four arbitrators) was adopted as a condition for keeping the provision unamended. As for the items that achieved 60%–79% agreement, they were reformulated and then presented in a second round. No item was deleted without dual justification: theoretical (lack of feature representation or semantic redundancy) and validity (subthreshold agreement after reformulation).

Table (2): Summary of judging procedures for the mental health scale

Round	Displayed items	Threshold of agreement	Paraphrased items	Items deleted	Items added
The first	56	80%	11	8	8
Second	14	80%	3	0	0
Final	56	%80or more	—	—	—

Table (3): Matrix of modifications to the mental health scale (Matrix of Changes)

Modification	number	Theoretical justification	Psychometric/procedural
--------------	--------	---------------------------	-------------------------

type			justification
Items left unchanged	36	They represent general indicators of adjustment (satisfaction, stress tolerance, negative symptoms not related to the university context).	Inter-rater agreement $\geq 80\%$; Item-to-college correlations are between 0.31 and 0.64.
Deleted items	8	It was linked exclusively to the student context (specialization, university, academic value in the country).	Poor apparent fit for the target sample according to the arbitrators' reports (agreement less than 80%).
Added items	8	Covering the social pressure related to delayed marriage: looks of pity, fear of loneliness with age, emotional emptiness despite achievement, family pressure, religious meaning, and financial independence.	Formulated according to the operational definition and then governed; It was retained after reaching the 80% threshold in the second round.
Modified clauses in wording	12	Transferring the wording from the student/major pronoun to the reality of an unmarried adult woman without changing the measured trait.	Linguistic modification based on judges' comments about ambiguity or reproach; Neither the item direction nor the correction key has been changed.
Items with marginal relevance were retained	2	Items 10 and 24 touch on empathic despair and conditional satisfaction, which are clinically significant in this category.	Their correlation with totality is close to the threshold of 0.30; They were kept due to their clinical importance, with caution within the limits of the study.

Internal consistency over the sample ($n = 78$): Correlations of items with the total score ranged between 0.31 and 0.64, all of which were significant at 0.01 except for items 10 and 24, which were close to the threshold. Reliability of the total score: Cronbach's $\alpha = 0.89$; Split-half reliability after Spearman-Brown correction = 0.86. They are good indicators that allow research to be credited to the overall degree.

.3.3 Revised Perceived Social Support Scale (24 items)

The modified scale (TPO) consists of 24 items equally distributed across three sources of perceived support, according to the multiple sources conceptualization established by Zimet et al. (1988) in the MSPSS scale, with the third source adapted to fit the Algerian context. The dimensions are:

A. Family support (8 items): Perception of the availability of emotional and instrumental support from the nuclear and extended family, and the absence of blame conditional on marital status.

B. Support from female friends and colleagues (8 items): Perceiving the availability of listening and accompaniment from peers, including female colleagues at work or school.

C. Support for the social and religious environment (8 items): perception of acceptance in gatherings, non-reductive social discourse, and religious meaning framework (including the items on divine providence and “marriage is a division and share”).

The scale: always = 3, sometimes = 2, rarely or never = 1. The dimension range is 8–24, and the total range is 24–72. A higher score indicates a stronger perception of the availability of support, rather than the objective size of the network.

The validity of the judges was conducted in parallel with the first scale and with the same threshold (80%). No items were deleted from the tripartite structure so as not to disturb the dimensional balance. The amendment was limited to reformulating four items to improve cultural specificity (replacing the “distinctive person” with a socio-religious source). Internal consistency: alpha for total score = 0.86; for family dimension = 0.84; For the dimension of female friends = 0.81; Perimeter dimension = 0.79. Dimensional correlations with totality range between 0.72 and 0.88.

Table 4: Matrix of modifications to the perceived social support scale

Modification type	NUMBER	Theoretical justification	Psychometric/procedural justification
Dimensional structure	8×3	Maintaining the logic of the three sources while replacing the “special person” with a social and religious environment that suits the Algerian context.	Balancing the number of items prevents the total score from being biased in favor of one dimension over another.
Modified clauses in wording	4	Avoid general, insensitive formulations of the stigma of delayed marriage.	Rework after reviewers' comments; Final agreement ≥ 80%.
Deleted/added items	0 / 0	The number of items was not replaced so that the comparison by dimensions remained equivalent.	Dimensional stability after adjustment remained in the acceptable range ($\alpha = 0.79–0.84$).

4. Statistical methods (SPSS 26)

After transcribing the Google Forms file into Excel and then importing it into SPSS, the negative items were reverse coded, and total and dimension scores were calculated. Used: descriptive statistics; Pearson correlation coefficient; T-test for two independent samples after checking homogeneity of variance with Levene's test; One-way analysis of variance (ANOVA) with post hoc Scheffé comparison; And alpha and split-half coefficients. The significance level was 0.05, with exact significance reported. The justification for maintaining the comparative analysis is that the second and third hypotheses test actual differences between independent groups, and not merely describe levels.

5. Ethical considerations

The form included a statement that participation was voluntary, and that the data was used for research purposes only, with the possibility of withdrawal before submission. No names or phone

numbers were requested. Given the sensitivity of the topic, the items avoided any wording suggesting blame or urging marriage, and focused on feelings and resources, not disability.

Fourth: Presentation and discussion of the results

1. Descriptive levels of the two variables

Table (5): Descriptive statistics for the total score and dimensions (n = 78)

variable	Number of items	Theoretical range	Average	Deviation	level
Overall mental health	56	168–56	121.34	18.41	Medium to high
Total social support	24	72–24	55.21	8.93	High average
Family support	8	24–8	19.82	3.41	Relatively high
Supporting friends/colleagues	8	24–8	17.36	3.88	Average
Social and religious support	8	24–8	18.03	3.27	Medium to high

The sample means lie above the middle of the theoretical range on both variables. This picture does not mean the absence of suffering; The distribution of mental health shows a clear variance ($p = 18.41$), meaning that the average hides a variance between the cohesive category and the burdened category.

Table (6): Distribution of levels of mental health

level	Range	Frequency	Percentage%
Low	93–56	11	14.1
Average	131–94	42	53.8
High	168–132	25	32.1
Total	—	78	100

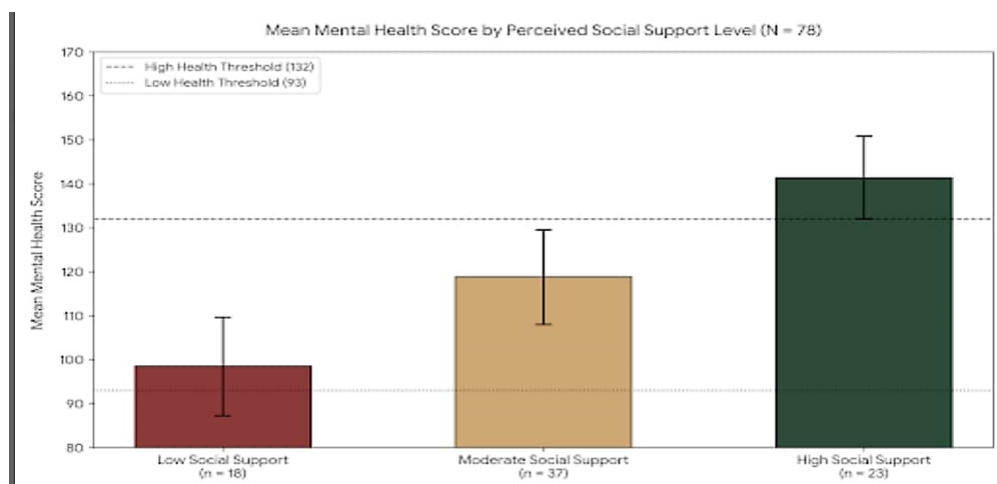


Figure (1): Average mental health according to the level of perceived social support (low/medium/high)

The gradient of average mental health with height in the perceived support category is clear from Figure 1: the low-support category (n = 18) approaches the low-level threshold, while the high-support category (n = 23) exceeds the high-level threshold. This descriptive pattern supports the hypothesis of subsequent association without being interpreted causally.

2. Results of the general hypothesis: correlation

Table (7): Pearson correlation coefficient between perceived support and mental health

Variables	R. Pearson	Denotation (binary)	N
Total support x total mental health	0.61	0.000	78
Family support x mental health	0.58	0.000	78
Supporting friends × mental health	0.47	0.000	78
Social and religious support x mental health	0.52	0.000	78

The general hypothesis is accepted: the relationship is moderate to strong positive and significant at 0.001. The coefficient of determination $R^2 \approx 0.37$, meaning that about 37% of the variance in mental health can be statistically attributed to the variance of perceived support, which is a significant percentage in field correlational research on psychosocial phenomena. The result is consistent with the protective barrier model and with the results of Qanoon (2016), Dalal (2022), Al-Saadi (2021), and Qandil (2025), although the samples differ.

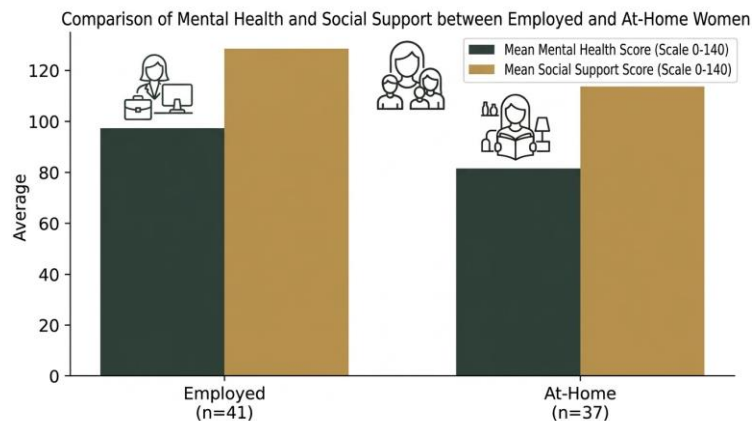
The order of the strength of attachment (family, then religious-social environment, then friends) has a cultural significance that can be tested: the family is still the most emotionally intense source in Algerian society, even when it is itself a potential source of pressure. The socio-religious dimension provides a meaning framework that may mitigate the interpretation of delay as a defect. The support of female friends seems important but less stable; Perceived availability may weaken as female friends themselves transition into marriage and childbearing.

3. Results of the second hypothesis: differences according to work

Table (8): T-test for differences between female workers and those who stay at home

variable	Group	ن	Average	A	T	D.H	Connotation
Mental health	Female workers	41	128.61	16.22	4.18	76	0.000
Mental health	Stays	37	113.27	17.84			
Total support	Female workers	41	58.37	7.91	3.46	76	0.001
Total support	Stays	37	51.70	8.88			

Figure (2): Comparison of working women and stay-at-home women in mental health and perceived social support



The second hypothesis is accepted. Levene's test was not significant (acceptable homogeneity). The effect size (Cohen's d) for mental health is ≈ 0.90 , which is large. Professional excellence can be interpreted through four interrelated paths and not as a single cause: economic independence linked to a decrease in fear of want; A network of colleagues constitutes a parallel dimension of support; An identity of achievement that is not reducible to marital status; and reduced hours of exposure to repetitive domestic discourse about marriage. This interpretation is consistent with Obaid and Laitem's (2020) analysis of the repercussions of delayed marriage on working women, and with Botvinusht's (1984) and Mathar's (2007) approach to the role of work in rearranging female status. However, the result does not mean that work is a guarantee of compatibility. Some female workers scored low, especially when work pressure combines with severe family pressure and the absence of close friends. Work is a potential facilitating condition, not a sole determinant.

4. Results of the third hypothesis: differences according to education

Table (9): One-way analysis of variance for mental health according to educational level

Source of variance	Sum of squares	D.H	Mean squares	F	Connotation
Between groups	2486.41	2	1243.21	3.92	0.024
Within groups	23791.18	75	317.22		
Total	26277.59	77			

Table (10): Averages by educational level and Scheffé comparison

level	N	Average health	Function comparison
Secondary or less	19	112.05	It differs from undergraduate and graduate studies
University	46	123.17	Different from secondary school
Postgraduate studies	13	128.46	Different from secondary school

The third hypothesis is partially accepted: the difference is significant, and it is mainly between the secondary school category or less on the one hand and the two university categories on the other hand, without a significant difference between the bachelor's/master's degree and postgraduate studies. Higher education is associated with a discourse that is better able to attribute delay to structural conditions (marriage market, high housing, partner selectivity) rather than self-blame. It also opens professional and academic networks that may expand perceived support.

5. Synthetic discussion

The results depict a heterogeneous population: the majority of the sample is not in the low mental health zone, their family support is relatively high, and the association between resource and outcome is statistically significant. This does not deny the presence of 14.1% in the low level, and they are the group that deserves clinical priority, given what the negative items reflect of insomnia, self-blame, fear of loneliness and need, and disguised sadness.

The correlation can be read as a potential reciprocal pattern rather than a settled causal arrow: a psychologically healthier girl may be better able to seek support and maintain friendships, and perception of support may nurture health. The cross-sectional correlational approach does not determine the direction, but the theoretical model and research heritage make the hypothesis of "support protects health" a hypothesis guiding intervention, not a proven causal result.

Culturally, stigma appears to be present in negative items (view of inferiority, pity, changing behavior to please people). The decrease in its perceived impact is linked to a family discourse that recognizes the value of the daughter in her present, and a religious discourse that provides the framework of "division and share" without turning it into a tool of blame or an order for negative patience. The distinction between religiosity that gives meaning and religiosity that burdens women with the burden of "lack of facilitation" is a clinical distinction that counseling programs should pay attention to.

The preference for female workers is consistent with the sociological analysis that believes that going out into the public space breaks the family's monopoly on defining value. However, 78.2% still live with the original family, which means that work does not automatically translate into residential independence, and that daily negotiation with the domestic discourse remains a primary arena for intervention.

Fifth: Conclusion and recommendations

1. General conclusion

On a sample of 78 girls who were late for marriage in the state of Algeria, whose data were collected electronically using a snowball method and analyzed with SPSS, it was found that perceived social support is positively and significantly related to psychological health, that the family is the strongest source of connection, and that work and higher education are associated with higher degrees of compatibility. The phenomenon is not an inevitable synonym for psychological collapse, but rather a stressful situation, the effect of which is mediated by the awareness of the bond and the opportunities to build an identity that is not reduced to the marital state.

2. Procedural recommendations

First: University and community psychological counseling centers should include support group programs for girls over 35 years old that focus on reinterpreting stigma, skills in seeking support, and dealing with social questions, not on marriage as a therapeutic goal.

Second: Directing family guidance to parents and siblings to modify the discourse: refrain from public pity and comparison with married women, and explicitly acknowledge the daughter's professional and humanitarian value.

Third: Taking advantage of the religious dimension as a framework of meaning and not as an additional pressure tool. That is, a discourse that separates belief in fate from holding women responsible for "delaying the share".

Fourth: Encouraging paths to economic and residential independence as mental health resources, not as an alternative to or the opposite of marriage.

Fifth: Adopting the two modified scales - after further codification on larger samples - in clinical practice for rapid detection of low-level patients.

3. Limitations and prospects of the study

Limitations of the study: Non-probabilistic online sampling may favor female learners and network users. The relative small size (78) limits the generalizability of factor analysis or structural modeling; The cross-sectional design prevents causality from being determined; Limiting it to the state of Algeria limits the generalizability of the results to the countryside and the south. The adapted scale also needs to be re-standardized on a larger sample, with a factorial validity examination that confirms or modifies the five proposed content areas.

As for the prospects: a longitudinal study that tracks the change in support and health over two years; Introducing mediating or modifying variables (psychological hardiness, thinking styles, social alienation, internal versus social religiosity); Urban-rural comparison; An in-depth qualitative study of the content of daily family discourse.

Sixth: List of references

The references are arranged alphabetically according to the APA system (seventh edition). The works of Arab authors are mentioned by the family name and then the first letter of the name.

Arabic references

Blairdouh, K. A. (2021). The psychology of optimism and pessimism and their relationship to anxiety about the future: a field study with some women who are late for marriage. *Journal of Social Sciences*, 11, 9–34.

Botvanusht, M. (1984). *The Algerian family: development and modern characteristics*. Office of University Publications.

Dalal, S. (2022). The effect of psychological stress and perceived social support on life satisfaction among parents of children with chronic diseases. *MELAF Journal of Research and Studies*, 8(2), 188–201.

Zarqi, A. (2019). Self-esteem among unmarried women: a case study. *Al-Mubashir Journal of Legal and Political Studies*, 5, 228–251.

Zatoto, N. (d.t.). Depressive response in unmarried women and its relationship to ambiguity in thinking: a comparative study between unmarried women and married women [Unpublished dissertation]. University of Algiers 2.

Al-Saadi, M. (2021). The predictive ability of perceived social support in psychological immunity among refugee women. A field study in Jenin camp.

Obaid, T., and Laitem, N. (2020). The phenomenon of delayed marriage and its repercussions on working women in Algeria: a field study on a sample of female workers in the city of Skikda. *Journal of Human Research and Studies*, 14(1), 7–56.

Qandil, H. A. A. (2025). The mediating role of perceived social support in the relationship between cognitive distortions and suicidal ideation in adolescents. *Journal of the Faculty of Arts, Port Said University*, 31, 337–414. <https://doi.org/10.21608/jfpsu.2024.330253.1394>

QAnon, Kh. (2016). Perceived social support and its relationship to depression among people with infectious diseases: a study on a sample of hepatitis C patients at the Batna State University Hospital. *Journal of Social Sciences and Humanities*, 10, 213–232.

Karkush, F., and Sharadi, N. (2014). An analytical study of the reality of delaying the age of marriage in the Arab world - Algeria as an example. *Al-Hikma Journal for Educational and Psychological Studies*, (29), 253–280. <https://doi.org/10.12816/0044014>

Makkawi, p. F. M. (2002). Mental health scale. University of Algiers.

Foreign references

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310–357. <https://doi.org/10.1037/0033-2909.98.2.310>

Mathar, A. (2007). Mutations familiales et âge au mariage en Algérie. Office des Publications Universitaires.

Toualbi, N. (1984). L'identité au Maghreb: L'errance. ENAL.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, 52(1), 30–41. https://doi.org/10.1207/s15327752jpa5201_2

Appendix: A reminder of the structure of the two tools used

Revised mental health scale: 56 items, of which 24 are positive (1, 2, 3, 5, 6, 9, 11, 12, 13, 16, 20, 21, 24, 25, 26, 28, 30, 38, 39, 44, 47, 48, 49, 52) and 32 are negative, the scores of which are reversed. The ladder is triple. Range 56–168.

Perceived social support scale: 24 items on three equal dimensions (8 + 8 + 8), three-dimensional scale (always / sometimes / rarely or never), total range 24–72. The first dimension is family, the second is friends and colleagues, and the third is the social and religious environment (it includes the divine care item and the “marriage is a division and share”) item.

Responses were collected via Google Forms and coded in SPSS 26 according to the above correction key before extracting the tables presented in the body.

The scale can be viewed according to the following link:

https://docs.google.com/document/d/1aQq0Qdyn5_40iVoPpaYS6VvY0xRqdmKUTCUKvX91X18/edit?usp=sharing