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The bidirectional impact of perceived and enacted support on mood in bipolar outpatients: A two-year prospective study

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Abstract

Bipolar disorder (BD) is a chronic illness, and a great need has been expressed to elucidate factors affecting the course of the disease. Social support is one of the psychosocial factors that is assumed to play an important role in the course of BD, but it is largely unknown whether the depressive and/or manic symptoms also affect the patients' support system. Further, the perception of one's social support appears to have stronger effects on disease outcomes than one's enacted or received support, but whether this also applies to BD has not been investigated. The objective of this study is to examine temporal, bidirectional associations between mood states (depression and mania) and both enacted and perceived support in BD patients.

The current study was conducted among 173 BD I and II outpatients, with overall light to mild mood symptoms. Severity of mood symptoms and social support (enacted as well as perceived) were assessed every 3 months, for 2 years (1146 data points). Multilevel regression analyses (linear mixed-models) showed that lower *perceived* support during 3 months was associated with subsequent higher levels of depressive, but not of manic symptoms in the following 3 months. Vice versa, depressive symptoms during 3 months were associated with less perceived support in the following 3 months. Further, manic symptoms during 3 months were associated with less *enacted* support in the subsequent 3 months.

The current study suggests that perceived, but not enacted, support is consistently related to depressive symptoms in a bidirectional way, while mania is specifically associated with a subsequent loss of *enacted* support. Clinical implications of the current findings are discussed.
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1. Introduction

The longitudinal course of both bipolar disorder (BD) I and II is usually chronic and often characterized by permanent minor or subclinical mood symptoms and relapse into full mood episodes [1,2]. The treatment of BD focuses on stabilizing acute mood episodes and preventing relapse when euthymia is established. To this end, pharmacotherapy has generally been the main treatment strategy, but over the last decade, the additional value of psychotherapeutic interventions in the treatment of bipolar patients has become increasingly evident [3,4]. Evidence based psychotherapies for BD are psycho-education (preferably with a significant other), family focused therapy (FFT), interpersonal social rhythm therapy (IPSRT) and cognitive behavioral therapy (CBT) [5]. The majority of these therapies put substantial emphasis on the psychosocial context of the patient, since contextual factors like negative life events [6,7] and family distress [8,9] are consistently associated with increased relapse risks in BD. Inversely, bipolar patients with supportive relationships seem to have a more favorable course than patients that lack this support [for review see: 10]. Based on these findings, it seems plausible that the promotion of supportive interpersonal relationships will lead to a more favorable course of the disease. However, so far the number of studies are limited, and more specific data

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regarding the influence of the different kinds of support are needed. The different kinds of support can roughly be divided into *enacted or objective* supportive interactions on the one hand and *perceived or subjectively felt* social support on the other hand. Although this distinction might seem rather arbitrary, numerous studies among different non-bipolar populations, including patients with unipolar depression, consistently found that perceived support, rather than the enacted social support, affects psychiatric and general health outcomes [e.g. 11–13]. In these studies perceived support is generally defined as the subjective perception that support is available, adequate and sufficient, while enacted support refers to the actual received support within a specific time frame [12,14].

Besides the fact that low levels of perceived support may lead to a more unfavorable course of the disease, it is also plausible that a persons' mood symptoms might affect the available support or the way support is perceived [15]. For example, people with depressed symptoms also tend to generate more strain in their relationships and thereby weaken their social support system [16,17]. To our knowledge, only Eidelman et al. [18] investigated bidirectional effects of social interactions in a bipolar sample over two time points with a relative short follow-up time (28-days). They found that both manic and depressed symptoms were related to more subsequent social strain. No evidence was found for associations in the opposite direction (social strain predicting mood changes), nor for associations between social support and mood symptoms.

In sum, there might be specific and bidirectional associations between perceived and enacted social support and the bipolar mood course, although this has not been studied in BD samples specifically. In order to improve the effectiveness of psychosocial interventions for bipolar patients, a better understanding is needed of the associations between social support and mood and potential differential effects of perceived and enacted support. The current prospective study is thus the first to investigate the lagged effects of social support (perceived as well as enacted) on mood state and vice versa in a large sample of patients with bipolar disorder.

2. Method

2.1. Participants

This is a 2-year prospective study among 173 bipolar I and II outpatients of the Outpatient Clinic for Mood Disorders in The Hague (The Netherlands). All patients were treated in accordance to the contemporary guidelines for bipolar disorder. Patients were invited to participate in the study either by letter or by their treating physician. After written informed consent was obtained, 173 patients were willing to participate and enrolled into the study and completed at least 2 consecutive waves. Participants were older than 18 years and exclusion criteria in this study were schizo-affective disorder, neurological disease and substance abuse disorders.

Diagnoses of BD were based on *DSM-IV* criteria and were assessed by trained research assistants, with a standardized diagnostic interview [19] using the Dutch version of the MINI International Neuropsychiatric Interview Plus (version 5.00-R; MINI-PLUS). *DSM-IV* axis II comorbidity was not assessed. The Questionnaire for Bipolar Illness, Dutch translation [20,21] was used to specify subtypes of BD and detailed information about disease characteristics (e.g. age of onset, number of previous episodes).

Fig. 1 shows the flow-chart of the participation rate of the patients at the different time points. In total there were 1146 data points with complete data during 24 months of follow-up. Of the total sample, 83.8% of the patients (n = 145) completed at least 1 year follow-up, with a cumulative number of 50 (28,9%) patients dropping out before the end of the study. There were no significant differences in baseline demographic and clinical characteristics between the group who participated until the end of the study (n = 123) and the group that dropped out during the study (n = 50). Moreover, during the study no differences in course severity were found among these two groups, and the number of hospital admissions was the same in both completers and dropouts, during the study as well as in the first 3 months after dropping out (based on file study).

2.2. Procedure

After completing the baseline assessment, patients had face-to-face contacts with trained research assistants at 3-, 6-, 9-, 12-, 15-, 18-, 21-, and 24-months follow-up. During these contacts, mood based functional impairment (Life Chart), medication use and social support were assessed (see Fig. 1). The study protocol was approved by the local ethical committee, and was carried out in accordance with the Declaration of Helsinki.

2.3. Social support List

The Social Support List (SSL) [22] was used to assess social support every 3-months during the 2 year study. The SSL is a commonly used scale [e.g. 23–25] to assess different domains of social support. The test–retest reliability and convergent validity yield satisfactory indexes [22,26]. This 41-item list is developed in the Netherlands and distinguishes three separate dimensions: Enacted social support, perceived social support and negative interactions. The negative interactions dimension is beyond the scope of the current study and therefore not included.

(i) Enacted social support
This subscale reflects the enacted amount of supportive interactions a person experiences. This part of the questionnaire starts with the question 'Does it ever happens that someone….', followed by 34 statements such as: 'calls you for a chat', 'visits you', 'cheers you up', 'asks you for help', etc. These items have a 4-point Likert scale: (1) 'rarely/never', (2) 'sometimes', (3) 'often', (4) 'very

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