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ORIGINAL ARTICLE

The influence of social support on patients' quality of life after an intensive care unit discharge: A cross-sectional survey

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Summary
Objectives: To determine the influence of instrumental, emotional and informative support on the quality of life of former intensive care unit (ICU) patients and to establish their preferred sources of social support.
Research methodology: In a cross-sectional survey, former intensive care patients ($n = 88$) completed the ''social support interactions/discrepancies list'', the ''RAND-36 Health Survey'' and reported their preferred sources of the different types of social support.
Setting: A 35 bed intensive care unit in the Radboudumc university hospital in the Netherlands.
Main outcome measures: Psychological, physical and social domains of quality of life and patient preferences regarding sources of social support.
Results: Instrumental and emotional support show a buffering effect on the physical dimension of the quality of life. The discrepancies between the expected and the received instrumental, informative and emotional support have a negative influence on psychological quality of life. Former ICU patients prefer receiving social support from family members rather than friends, professional caregivers or fellow former ICU patients.
Conclusion: This study emphasises the buffering effect of social support on diminished quality of life in former intensive care patients. It is suggested that hospitals provide an intensive care after-care programme including both patients and relatives to help fulfilling this need for social support.

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Implications for Clinical Practice

- Providing social support can enhance the diminished physical dimension of quality of life of former ICU patients.
- Former ICU patients prefer to rely on their family members regarding any kind of social support.
- Hospitals should focus on the primary social network of former ICU patients regarding the social support needs in ICU after care programmes.

Introduction

Available treatment options increase for even the most seriously ill patients as medical science progresses. Their majority stays in an intensive care unit (ICU) of a general hospital, where specialised personnel with advanced medical technologies try to prevent an otherwise certain death. It is estimated that the number of ICU days will increase by 17% from 2006 to 2016 (Hansen et al., 2008). In the Netherlands, 81,921 people were treated in an ICU in 2013 and this number will rise to nearly 100,000 during the years to come (Nationale Intensive Care Evaluatie, 2014). Therefore, the long-term outcomes of an ICU admission become increasingly important. Appropriate ICU-follow-up care is and will be crucial to prevent chronic disability, mental disorders and to ultimately reduce healthcare costs.

During their ICU stay patients are exposed to high levels of stress due to the deterioration of their physical condition, the invasive treatment and the reduced possibilities to communicate. Even discharged ICU patients face significant physical, and social limitations caused by a reduced cardiac reserve, pulmonary problems or neurological symptoms (Davydow et al., 2009; Griffiths and Jones, 1999; Svenningsen and Langhorn, 2015). In addition, a considerable number of former ICU patients suffer from anxiety, depression and Post Traumatic Stress Syndrome (PTSS). Moreover, former ICU patients state to have a diminished quality of life (QOL) (Cuthbertson et al., 2004; Myhren et al., 2010; Svenningsen and Langhorn, 2015). Apparently, this is independent of the severity of the disease or length of stay in the ICU (Cuthbertson et al., 2004; Perrins et al., 1998; Svenningsen and Langhorn, 2015).

Stress can be defined as a condition in which the person—environment interactions lead to a discrepancy between demands of a situation and the resources of the individual (Lazarus and Folkman, 1984). Because ICU patients face a life threatening illness, have limited understanding of their situation and have diminished communication skills, their admission is often estimated as very stressful. When this situation lasts, for instance due to ICU related disabilities, stress may become chronic and feelings of helplessness may accumulate its impact by decreasing self-care, self-confidence and the QOL even further (Cohen and Underwood, 2000; Cohen and Wills, 1985; Lazarus and Folkman, 1984).

According to Lazarus and Folkman (1984), coping is ''the constantly changing cognitive and behavioural effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person''. Thoits (1986) states that the social environment can provide informative, emotional and instrumental support to assist in coping behaviour. Social support can then act as a buffer and lessen or even prevent the stress from occurring. Social support will only be helpful when there is no discrepancy between what is desired and what is offered (Cohen and Underwood, 2000; Cohen and Wills, 1985; Lazarus and Folkman, 1984). The World Health Organisation (2014) states that QOL contains a physical, a social and a psychological dimension. All three dimensions can, in theory, be positively influenced by social support.

The aim of this study is to determine the relationship between social support and the patients' QOL after an ICU admission, in order to give recommendations for optimising ICU patient aftercare programmes. Therefore, the following research questions are stated:

- How does emotional, instrumental or informative support relate to the different dimensions of the QOL after an ICU admission?
- How does the discrepancy between the emotional, instrumental and informative social support as expected and as perceived relate to the different dimensions of QOL after an ICU admission?
- Who do former ICU patients prefer as their primary source of social support: family, friends, other former ICU patients or hospital staff?

Methodology

Participants, setting and ethical approval

A cross-sectional survey has been carried out among former ICU patients from the university hospital ''Radboudumc'' in Nijmegen, the Netherlands. 300 patients who were admitted between January 2010 and December 2012 were selected from the ICU admission database. This time frame was necessary to be able to recruit enough patients. Inclusion criteria were age (at least 18 years) and length of stay (at least three days). Eligible patients received an explanatory letter, an informed consent form, a questionnaire and a post-marked envelope at their home address by mail. A reminder letter was sent to all selected patients three weeks later. Anonymity was guaranteed using identification numbers. Ethical approval has been obtained from the ethical committee of psychology of the Open University of the Netherlands (9-26-2012; U2012/05451/NJA) and the head of the ICU and research committee of the Radboudumc.

Data collection

Two questionnaires were used to measure social support and QOL, respectively. The first is the social support interactions and discrepancies list (SSL-I/D). This Dutch questionnaire, with demonstrated validity and reliability (Commissie Test