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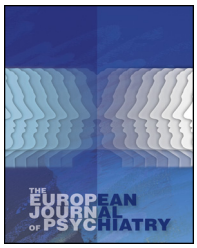

ORIGINAL ARTICLE

Association between social support and quality of life in patients with affective disorders

A. Zdun-Ryżewska[a,*], K. Basiński[a], M. Majkowicz[a], M. Podolska[b], J. Landowski[c], K. Walden-Gałuszko[d]

[a] *Department of Quality of Life Research, Medical University of Gdansk, Gdańsk, Poland*
[b] *''Meditest'' Medical Diagnostics, Szczecin, Poland*
[c] *Clinic of Psychiatric Diseases and Neurotic Disorders, Medical University of Gdansk, Gdańsk, Poland*
[d] *Department of Psychiatry, University of Warmia and Mazury in Olsztyn, Poland*

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KEYWORDS
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Abstract
Background and objectives: Despite seemingly simple relationships between the quality of life and depression, the relevant issues are still not fully understood. The aim was to study the role of social support in the quality of life.
Methods: The study included 104 patients with unipolar or bipolar affective disorder. Beck Depression Inventory and Hamilton Depression Rating Scale were used to determine the level of intensity of depressive symptoms. Quality of life (Quality of Life in Depression Scale) and levels of social support (parts of Berlin Social Support Scales, Social Support Scale) were measured on admission, at discharge from the hospital, and 3 months after discharge.
Results: Results showed an increase in quality of life during hospitalization. The amount of social support remained constant between three measurements and positively correlated with quality of life. The strongest associations (controlled by depression severity) were found for perceived support at discharge (controlling HRS Rho = −0.44; $p < 0.001$, controlling BDI Rho = 0.4; $p < 0.001$). Support from the person perceived as most helpful did not correlate significantly with quality of life on admission, at discharge and during follow-up. Interestingly, support from the person perceived as least helpful correlated with quality of life on admission (controlling HRS Rho = 0.39; $p < 0.001$, controlling BDI Rho = 0.27; $p < 0.05$).
Conclusions: During hospitalization, the quality of patient's life significantly improves with time. Social support is a significant correlate of quality of life in affective disorders.

* Corresponding author.
E-mail address: azdun@gumed.edu.pl (A. Zdun-Ryżewska).

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Introduction

Terms such as depression, mental health, and quality of life seem to be closely associated with one another.[1] Typically, depression refers to marked difficulties and poor quality of life.[2–7] The results of many studies suggest that the quality of life can markedly improve with time (as a result of effective pharmacological treatment of depressive symptoms or psychotherapy).[8–13] This association and its strength are to a large extent determined by the way the quality of life has been defined. Models and studies defining quality of life as an unidimensional variable (i.e. well-being) simplify this problem and bring it to an excessively basic level (typically, a depressed individual with decreased mood does not perceive him/herself to have a high level of wellbeing).[14] The multidimensional (for example function and need-based) approach to the quality of life raises more possibilities of interpretation.[3]

Social support and the quality of life in depression

Support can be defined as help which one can use in difficult situations.[15] As such, support reduces the risk of both mental and somatic disorders, modulates stress-coping approach, and diminishes the probability of premature death.[16,17] Additionally, social support is thought of as a significant determinant of the patient's quality of life. Jarema[18] observed that patients who were asked to rank the potential determinants of quality of life often placed support in the first place (followed by mental health, financial situation, and independence). This intuitive understanding of the role of social support was supported in empirical research.[19,20] Studies dealing with depression have produced similar findings. The relationship between the quality of life, depressed mood, and social support was documented by Friedman et al.,[21] Chan et al.[22] and Kuehner and Buerger[23] among others. Patients with affective disorders frequently perceive obtained support as inadequate to their needs.[24,25] Available data highlights a negative correlation between depression and the amounts of obtained social and emotional support, which translates into the quality of life.[26]

Despite the high severity of symptoms of depression, social support can serve as a protective buffer with regard to the perception of the quality of life; this is consistent with Cohen's and Wills concept[27] explaining the mutual relationships between support and the quality of life. They suggested two possible mechanisms: ''main effect'' and ''buffer against stress''. In the first case, the more social support in one's life the higher one's quality of life (the relationship between these two variables is linear). The ''buffer against stress'' explains this association in relation to stress. If stress is at a moderate level, the quality of life is not modulated by the amount of social support. In contrast, in the case of considerable accumulation of stress, social support serves as a protective buffer, clearly translating into the quality of life.

Psychiatric patients hospitalized for depression are especially prone to high levels of stress. Thus, an empirical research into the relationships between quality of life and social support in this group could potentially yield interesting and clinically significant results. Social support is thought of as vital for the recovery process in depression and for the quality of life. However, the strength of these relationships and the possibilities of the most effective utilization of social support in facilitating the recovery and improving the quality of life of patients with depression remain open to investigation. The aim of this research was to study the role of social support in the quality of life and to verify if the quality of life is modulated by various types of social support.

Material and methods

Participants

The study, conducted at the Academic Clinical Centre included 104 patients with unipolar (83% of the studied group) or bipolar affective disorder (17%), without other comorbidities or cognitive impairment hindering the understanding of questionnaire content. A history of depressive episodes was found in approximately 92% of the studied group; the remaining subjects were hospitalized for the first time. Sixty-six percent of the sample were female. The average age of the participants was 51 ± 13.2 years (Table 1).

Study design

The study was designed as a prospective observational study. The procedure included three measurements: (1) on admission (within one week after hospitalization; $N = 104$), (2) at discharge from the hospital with clinical improvement ($N = 66$), and (3) 3 months after discharge ($N = 40$). The study protocol included filling out questionnaires in the presence of a psychologist in the office in the clinic. The third meeting took place in most cases in the clinic, some patients did not want to go back to the hospital and offered a meeting in their own home. At the end of each meeting, the patients had the opportunity to talk to a psychologist.

The protocol of this study was approved by the Local Ethics Committee. The exact purpose of the study was explained to the participants and their written consent was obtained. The project is a continuation of research on the quality of life in depression – the first part of the research concerned with differences in the quality of life between patients with unipolar and bipolar affective disorder.[28]

Assessments

Quality of Life in Depression Scale (QLDS) enables the evaluation of quality of life (defined in relation to the concept of needs) in patients with depression.[29] QLDS consists of 34 statements and is completed by the patient himself/herself in about 7 min. A high score indicates low quality of life. The tool has been adapted to Polish conditions using the procedure of translation and retranslation and pilot studies which revealed satisfactory psychometric properties.[30]

The diagnosis of depression was established by the psychiatrist employed at the Academic Clinical Centre (using ICD-10), and the severity of depressive symptoms was determined with two scales: the subjective Beck Depression

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