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Research report

Determinants of subjective quality of life in depressed patients: The role of self-esteem, response styles, and social support

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Abstract

Background: We aimed to assess the subjective quality of life (QOL) in depressed patients after discharge from inpatient treatment and to investigate the net impact of self-related constructs (self-esteem, response styles to depressed mood) and of social support on specific subjective QOL domains.
Method: Four weeks after discharge from inpatient treatment, 89 unipolar depressed patients were assessed with a comprehensive battery of psychopathology and psychosocial measures. Subjective QOL was assessed using the World Health Organization Quality of Life Scale (WHOQOL-BREF). Analyses included hierarchical regressions.
Results: Non-remitted patients reported poorer subjective QOL than fully and partially remitted patients regarding physical and psychological health, and overall QOL. After adjusting for demographic and clinical history variables, interviewer-rated severity of depression accounted for 4% to 36% of the variance in individual QOL domain scores. Self-esteem, rumination, distraction and the existence of a partnership added further increments to the explained variance of the psychological QOL domain. Rumination, partnership, and network size of family members providing psychological crisis support also predicted subjective QOL on the social relations domain.
Conclusion: Our results suggest that self-esteem, response styles to depressed mood, and social support characteristics contribute substantially to the psychological and social domains of subjective QOL in depressed patients. These associations are not attributable to concurrent symptom severity. Therapy with depressed patients should not only focus on symptom reduction but should help the patients to establish and maintain supportive relationships and to enhance self-appreciation and skills to cope with negative mood in order to improve psychological well-being and health-related quality of life.

Keywords: Depression; Quality of life; Self-esteem; Response styles; Social support

1. Introduction

Health related subjective quality of life (QOL) is conceptualized as a generic, multidimensional construct that describes an individual's subjective per-

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ception of his or her physical health, psychological health, social functioning, environment, and general life quality (e.g., WHOQOL Group, 1998; Bullinger, 2003). In recent years, this concept has been increasingly accepted as an important outcome measure in patients with somatic and mental illnesses (Demyttenaere et al., 2002).

Within the mental health field, research has shown that subjective QOL is particularly poor in depressed patients. Respective evidence comes from community studies (Goldney et al., 2000) as well as from studies in primary care (Ormel et al., 1999) and specialized mental health settings (Atkinson et al., 1997; Kuehner, 2002). Furthermore, subjective QOL of patients with depressive disorders has been found to be equally low or even lower than that of patients with major chronic medical conditions (Hays et al., 1995; Bonicatto et al., 2001). In this context, subjective QOL has also been linked to depression severity (Koivumaa-Honkanen et al., 2001; Lasalvia et al., 2002; Pyne et al., 2003). This is particularly true for QOL dimensions that resemble diagnostic criteria for depressive symptoms and impairments, pointing to the problem of a partial overlap between the constructs (Kuehner, 2002). However, there is general agreement that subjective QOL may be regarded as a multifactorially determined construct that is not redundant with self-rated depression (Skevington and Wright, 2001; Demyttenaere et al., 2002; Kuehner, 2002).

Interestingly, little attention has been directed toward other factors that might contribute to the subjective QOL of depressed patients apart from symptom severity. For example, while it has been shown that psychosocial factors partly determine the perceived QOL in psychiatric patients, respective research has hitherto mainly focused on schizophrenic or diagnostically heterogeneous samples (Ruggeri et al., 2001; Ritsner et al., 2000, 2003; Bechdolf et al., 2003; Gureje et al., 2004).

Both self-esteem and a ruminative coping style with depressed mood have been found to be related to the onset and maintenance of clinical depression (Ezquiaga et al., 1999; Hoffmann et al., 2003; Pelkonen et al., 2003; Nolen-Hoeksema, 2000; Kuehner and Weber, 1999), but little or no work has been done to eludicate their protective or deleterious role for the subjective QOL in depressed patients. From a general health perspective, self-esteem is assumed to be crucial to mental and social well-being by influencing aspirations, personal goals, and interaction with others (Mann et al., 2004). High self-esteem is also seen as a protective factor in depression by helping vulnerable individuals to cope with the psychological consequences of the disorder (Aro, 1994). Similarly, a ruminative tendency to cope with depressed mood is assumed to impact psychological well-being (Nolen-Hoeksema and Rusting, 1999) as well as complex interpersonal problem solving (Nolen-Hoeksema, 1998). In fact, recent research has shown that rumination is linked to interpersonal problems (Nolen-Hoeksema and Davis, 1999; Lam et al., 2003).

Aim of the present paper was to assess the subjective QOL of patients suffering from unipolar depression in relation to their clinical remission status at discharge from inpatient treatment. A second aim was to assess the contribution of self-related cognitive constructs such as self-esteem and response styles to depressed mood, as well as of social support, on various dimensions of subjective QOL in these patients.

Specifically, we hypothesized that self-esteem and response styles to cope with depressed mood would predominantly contribute to the psychological and social relations domains of subjective QOL. We also predicted an association between the presence of an intimate partnership and of social support network sizes of families and friends with subjective QOL in the psychological and social relationship domains (cf. Miller et al., 1992; Keitner et al., 1995; Hirschfeld et al., 1998; Holahan et al., 2004). Other QOL domains, such as physical health and environmental aspects, were assumed to be less influenced by the assessed self-related constructs and social support characteristics.

In this context, we were particularly interested in determining the relative or 'net' impact of the respective predictors. Accordingly, we employed a strict hierarchical approach that controlled for demographic, clinical history, and symptom-related variables assumed to have an impact on subjective QOL outcomes.

2. Method

2.1. Design

Unipolar depressed patients aged 18–70 were recruited consecutively into the study before discharge