Print ISSN: 2735 – 4121 *Online ISSN : 2735 – 413X*

SOCIAL SUPPORT AND ITS RELEVANCE TO RELAPSE AMONG PATIENTS WITH BIPOLAR DISORDER

Mona El-Bilsha, Mohamed Ezzat El-hadidy, Alaa Mohamed Aid

Mansoura university, Psychiatric and Mental health

Corresponding Author: Alaa Mohamd Abd elhamid Aid (aid.alaa@yahoo.om)

Abstract:

Bipolar Disorder (BD) affects and is affected by the family atmosphere. About social support and bipolar disorder, supporting partnerships tend to have beneficial impact on avoiding a relapse and also improving medication commitment and strengthening the individual's functionality. So, this study ***aims*** *to assess the relationship between social support and its relevance to relapse among patients with bipolar disorder.* ***Method:*** *A descriptive correlational research design was utilized with a sample of 200 patients diagnosed with bipolar disorder attending the Inpatient and the Out-patient Clinics of Psychiatric Department of Mansoura University Hospital. Data was collected using two tools: tool to assess socio-demographic characteristics and clinical data and the Multidimensional Scale of Perceived Social Support (MSPSS) tool.* ***Results*** *revealed that more than one third of the studied sample (36%) was less than 30 years, more than half (71%) were males, arround half of the studied sample (47.5%) were single , according to the level of education (13%) were illiterate and (21%) read and write (primary/preparatory), more than half of the studied sample (54%) had previous psychiatric hospital admission from 5 to more than 10 times. Also half of the studied sample had low social support and patients who had low and moderate social support admitted to the hospital from 5 to 10 times and more.* ***Conclusion:*** *It can be concluded from the present study that low social support increases the risk for relapse among patients with bipolar disorder.*

Keywords: *Bipolar disorder; relapse; social support*

Introduction:

Social support can be described as conducts from individual's members of an informal social network (e.g friends and family) that are intended to provide assistance, either in general or with respect to a specific stressor **(MacGeorge, Feng & Burleson, 2011) .**

Social support can be broadly defined as the emotional (e.g., reassurance, encouragement), informational (e.g., advice, direction) or instrumental (e.g financial aid, physical help) resources provided from individuals' social networks **(Gottlieb & Bergen , 2010)** and that support actually may be received from others or simply perceived to be available when needed **(Toits ., 2010)** .

Brown (2015) described social support as the degree to which the essential social needs of a person are provided by contact with others and the sense of connection that the wants of individuals are understood and recognized that when they need help and feel lonely, people respect their needs and care for them.

Categories of social support:

Cutrona and Suhr (1992) describe a framework of social support categories that includes five general categories of social support:

informational, emotional, esteem, social network support and tangible support.

Informational support refers to message containing information or facts, such as advice or feedback on actions. Emotional support is associated with caring, concern, empathy, and sympathy. Esteem support is described as messages that help improve one's skills, abilities, and intrinsic value **(Hsiu-Chia, Wang & Yi-Ting , 2013) .**

Support for social network is defined as the messages that help strengthen one's sense of belonging to a particular group with the same interests or circumstances. Finally, tangible support is perceived as physically supplying recipients with wanted goods and services . There are several subcategories in each one of the five categories **(Hsiu-Chia, Wang & Yi-Ting , 2013)** .

Social support and its effect on Bipolar disorder:

Bipolar illness disturbs and is influenced by the home environment **(Reinares et al., 2016).**The presence of social support signifies the accessibility of individuals nearby to us on whom one may rely and individuals who accept our beliefs and affection. Social help increases the ability to endure distress and resolve disappointment **(Dixit, Chauhan & Azad, 2015)**. Concerning social support and BD, Supportive relationships appears to have positive effects on the prevention of a relapse, and also on better adherence to treatment and improved ability of individual to function (**Oddone, Hybels, McQuoid & Steffens, 2011)**

Each new relapse is an exhausting event that triggers painful feelings and destroys the patient's life. It is mutual for caregivers to neglect their and other family members' requirements by taking care of the patient; and, even when the patient is in remission, the worry of potential episodes is existent **(Reinares et al., 2016) .** Social support represent processes by which interactive bonds enables individuals to resolve the negative impacts of tension. Substantial study now shows that social assistance decreases or control the negative mental effect or vulnerability to traumatic life events and continuing life stresses **(Dixit et al., 2015) .**

Persons with BD who receive greater support from their intimate personal contacts members (e.g., friends, parents, siblings, spouse) are fewer possible to encounter symptoms and improve more easily when disorders occur **(Doherty and MacGeorge 2012).** In adult clients with bipolar one disorder, lower rates of social support tend to raise the likelihood of future symptoms of depression but not manic symptoms over time **(Weinstock & Miller, 2010).**

A research by **Sullivan, Judd, Axelson and Miklowitz (2012)** indicated that in adolescents with bipolar disorder, family stability, ability to adapt, and conflict may be good indicators of the direction of mood symptoms. The importance of family relationships and its contribution to relapse have recently been spotlighted in patients with psychosis aged between 17 and 40 years **(Koutra et al., 2015)**. People with bipolar disorder, on average, report being highly sensitive to interpersonal rejection, and those who report this sensitivity experience more depression over time **(Tommy & Johnson, 2013)** .

Research indicates that social support continue to be relevant throughout life, in that older (aged 50 and older) adults with BD report lower perceptions of social support than

controls, and they tend to have comparable deficits in social support to younger people diagnosed with bipolar disorder **(Sheri, Johnson, Cuellar & Gershon, 2016)** . In guiding older adults with bipolar disorder to seek care more rapidly when symptoms arise, social support often seems important **(Beyer et al., 2014) .**

Intervention for improving social support:

Promoting the social system as a key preventive mechanism means improving the supportive process to improve their safety factor and to establish methods of buffering the impact of potentially traumatic events. Enhancement activities of the support system defined by the NIC system **(Bulechek et al, 2008)** are listed as follows :

- Evaluate the psychological response to the support system's condition and availability.
- Identify the appropriateness of current social networks.
- Assess the extent of care for families and financial assistance.
- Determine support system currently used.
- Determine challenges to the use of support systems.
- Evaluate the present family situation.
- Advice the patient to engage in social and community functions.
- promoting interactions with people with shared needs and targets.
- Refer to the self- help group when needed.
- Evaluate the suitability of community services to determine strengths and weaknesses.
- Discuss a community-based promotion / prevention and recovery programs.
- Provide services in a caring and supporting manner.
- Involve family/significant others/friends in care and planning.
- Explain to those interested how they can help.

Social support can be used to develop and coordinate interventions in primary prevention. There are four kinds of possible interventions **(Stuart., 2013) :**

1- Patterns of social support may be used to analyze groups and neighborhoods to recognize challenges and populations at high risk. It would not only gather information on the quality of life, but also make evident the social alienation of a specific group and help to establish community-based services.

2- Links between community support system and formal mental health services should be strengthened. Health professionals are either not aware of the presence or service of community supply networks or are not comfortable with them. They should be taught how community services and social support networks should be used and utilized. Health care professionals need to be capable of identifying patients in need of social help and to offer them access to effective community support services.

3- It is possible to strengthen naturally formed caregiving relations. Health practitioners should provide knowledge and support to informal caregivers in the community. Informal support system provide the following:

- A suitable training place for the development of skills for problem solving skills.
- A forum in which individuals grow and improve by learning to direct themselves to the process of change.

4-It is possible to help individuals and groups build, manage, extend and use their social networks. For example, network therapy includes putting together or taking together the significant members of the network of relatives and friendship.

The emphasis is then on strengthening ties within the network and breaking cycles of dysfunction. For families that are disconnected and have exhausted networks, there may not be enough network members available for such strategy. planning for use of mutually supportive groups can be useful in this case.

Aim of the study:

This study aims to assess the relationship between social support and its relevance to relapse among patients with bipolar disorder.

Subjects &Method:

I. Subjects

Research Design:

This is a descriptive correlational research design .

Setting:

The research was performed at the Inpatient and the Out-patient clinics of Psychiatric Department of Mansoura University Hospital .

Study population:

Patients diagnosed with bipolar disorder were recruited during the period from January 2019 to September 2019 .

Sample:

A convenience sample of 200 adult patients diagnosed with bipolar disorder attending the Inpatient and Outpatient Clinics of Psychiatric Department of Mansoura University Hospital. The length of study 8 months. These subjects met the following criteria:

Inclusion Criteria

1. Diagnosis of bipolar disorder according to patient's records.
2. Age from 18-55 years old.
3. Both sexes.
4. At least second episodes of bipolar disorder.
5. Capable of communicating and responding.
6. Willing to share in the study.

Exclusion Criteria

1. Substance induced bipolar and related disorder.
2. Bipolar and related disorder due to another medical condition.
3. Schizo- affective disorders.

Tools for data collection:

Data was collected using two tools. These tools include:

Tool (1): Socio-Demographic and Clinical Data Characteristics:

The socio-demographic tool was developed by the researcher after review of literature to assess socio- demographic features like; name, age, gender, marital status, level of education, occupation, income.

The clinical data include diagnosis, early onset, period of the disorder, numbers of prior admission to psychiatric hospital, family history of psychiatric illness, financial support, medication adherence, awareness of mental illness, seeking medical help, social interaction, availability of health services, stigma and seeking traditional healer.

Tool (2): Multidimensional Scale of Perceived Social Support (MSPSS):

This scale was developed by **Zimet, Dahlem, Zimet and Farley (1988) .** It is a 12-item scale that measures family, friends, and a significant other's perceived support. On a 7-point Likert-type scale, respondents react (very strongly disagree to very strongly agree).

The scale was translated into Arabic and validated by **Merhi and Kazarian (2012) .** The internal consistencies of Family, Friends and Significant Others of sources of social support for the total sample were high (α = .82, α = .86 and α = .85 respectively).

Scoring :

To calculate total score add together all 12 items, then divide by 12. To calculate subscale scores : Significant other subscale: add together items 1,2,5&10, then divide by 4. Family subscale : add together items 3,4,8&11, then divide by 4. Friends subscale : add together items 6,7,9&12, then divide by 4. Any mean total score ranging from 1 to 2.9 could be considered low support , a score of 3-5 could be considered moderate support , a score from 5.1 to 7 could be considered high support .

II. Method:

1. An Ethical approval was gained from the Research Ethics Committee, Faculty of Nursing – Mansoura University.
2. The Head of the Psychiatric Department of Mansoura University Hospital received official approval for the conduct of the study.
3. Sociodemographic characteristics and clinical data tool was developed by researcher based on recent related literature.
4. A pilot study was performed on 30 patients from hospital and outpatient clinics at the Mansoura University Psychiatric Department to test the clarity, effectiveness and applicability of the tools. It was carried out one month before data collection, during the period from November 2018 to December 2018. The key research selection did not include the pilot study.
5. The collection of data was performed between January 2019 and September 2019 . Data was obtained sequentially from the Mansoura University Psychiatric Department's Inpatient and Out-patient Clinics.
6. Verbal consent to engage in the research was collected from patients.
7. Patients were informed of the security of the data obtained from the questionnaires and that no sense of identity was necessary by any means.
8. Questions were read in slang language to allow the patients to understand their meanings.
9. The researcher introduced herself to the participant and explained to them the nature and aim of the study. The interview with each patient lasted for 20-30 minutes .

Ethical Considerations and human rights:

An ethical approval was obtained from the Research Ethics Committee, Faculty of Nursing – Mansoura University. Patients gained informed verbal consent after describing the intent, risks, advantages and methodology of the research. Participants have been told that participation is voluntary and this would not affect their care or treatment if they don't want to participate in the research. They were told that personal details would be kept private and their personal information would not be directly connected to the findings. They have also been told that they have the right of withdrawal from the research without penalty at any moment.

Statistical analysis :

SPSS (statistical Package for Social Science) version 21 was used to analyze the results. To explain qualitative data, numbers and

percentages were used. To test the relation between categorical variables, a Chi-square test was used. Significance is given when the likelihood of error (P-value) is 5 percent or less than 5 percent for all statistical tests conducted.

Results

Table 1: Socio-demographic characteristics of the studied sample (n = 200)

Socio-demographic characteristics	N	%
Age (years)		
< 30	**72**	**36%**
30 – 55	**128**	**74%**
Mean±SD	**34.145±9.497**	
Gender		
Male	**142**	**71%**
Female	**58**	**29%**
Education		
Illiterate	**26**	**13%**
Read and write (primary/preparatory)	**42**	**21%**
Diploma/secondary school	**103**	**51.5%**
Higher education	**29**	**14.5%**
Marital status		
Single	**95**	**47.5%**
Married	**77**	**38.5%**
Divorced	**22**	**11%**
Widow	**6**	**3%**
Occupation		
Not working	**112**	**56%**
Working	**88**	**44%**
Residence		
Urban	**63**	**31.5%**
Rural	**137**	**68.5%**
Income satisfaction		
Un satisfactory		**52%**
Satisfactory	**104**	**48%**
	96	
Total	**200**	**100 %**

Table (1) shows that the age of the studied sample ranged from 18-55 years with mean ± SD of 1.64 ± .4812. More than one third (36%) is less than 30 years . More than half of the studied sample (71%) is male . Arround half of the studied samples (47.5 %) are single. According to the level of education (13%) of the studied subjects are illiterate and (21%) read and write (primary/preparatory) . Regarding to occupation, more than half of the studied samples (56 %) are not working (44 %) are working. More than two thirds (68%) are from rural areas. Nearly more than half of the studied samples (52%) report unsatisfactory income.

Table 2 : Clinical data of the studied sample (n = 200)

Clinical data	N	%
Diagnosis		
• Bipolar 1 , current episode mania	87	43.5%
• Bipolar1, current episode depression	7	3.5%
• Bipolar 1, mixed episode	14	7%
• Bipolar with psychotic features	30	15%
• Bipolar 1 mania with psychotic features	35	17.5%
• Bipolar 1 (mixed) episode with psychot features	9	4.5%
• Bipolar disorder comorbid with substan	18	9%
History of psychiatric illness in family		
Negative	108	54%
Positive	92	46%
Duration of illness		
<1 year	9	4.5%
From 1 – 5 years	96	48%
(6- 10) years	43	21.5%
>10years	52	26%
Age at onset of disease		
<30	142	71%
30-55	58	29%
First episode		
<1 year	9	4.5%
1-2 years	39	19.5%
3-5 years	56	28%
6-10 years	44	22%
>10 years	52	26%
Mode of admission		
Involuntary	161	80.5%
Voluntary	39	19.5%
Previous psychiatric hospitalization		
<4 times	91	45.5 %
5-10 times	66	33 %
>10 times	43	21.5 %
Smoking		
No	103	51.5%
Yes	97	48.5%
If yes :		
< 1 pack of cigarettes	75	37.5%
(1-3) pack of cigarettes	22	11%
Total	200	100%

Table (2) shows that more than one third of the studied samples has bipolar1 disorder, current manic episode (43.5)% followed by mania with psychotic features (17.5 %) then bipolar disorder with psychotic features (15%).

Arround the half of the studied samples (46%) has previous positive psychiatric history of mental illness. Arround the half of the studied samples (47.5%) has duration of illness from 6 years to more than 10 years. More than two thirds of the studied samples (71%) are less than 30 years old at onset of disease. Half of the studied samples had first episode from 3 to 10 years ago and (26%) had first episode more than 10 years ago. More than half of the studied samples (54%) had been previously admitted to psychiatric hospital from 5 to more than 10 times while around the half of the studied samples (45.5%) had previous psychiatric hospital admission less than 4 times.

Table 3: Frequency distribution of the studied sample according to social support and its subdomain:

variables	Frequency (N)	(%)
Social support:		
• **Low support**	**100**	**(50%)**
• **Moderate support**	**79**	**(39.5%)**
• **High support**	**21**	**(10.5%)**
Mean±SD	**3.338±1.124**	
Social support subdomains:		
1-For significant others		
• **Low support**	**83**	**41.5**
• **Moderate support**	**71**	**35.5**
• **High support**	**46**	**23**
2-For the family:		
• **Low support**	**79**	**39.5**
• **Moderate support**	**77**	**38.5**
• **High support**	**44**	**22**
3-For friends:		
• **Low support**	**149**	**74.5**
• **Moderate support**	**45**	**22.5**
• **High support**	**6**	**3**
Total	**200**	**100**

Table (3) shows that half of the studied samples (50%) has low social support system compared to those who have high social support system which represent (10.5%) among the studied samples. Concerning the social support subdomains, more than one third of the studied sample has low social support system for significant others (41.5%) and also more than one third of the studied

sample has low social support system for the family (39.5%) and more than two thirds of the studied sample (74.5%) has low social support system for friends.

Discussion:

The present study reveals that half of the studied sample had low social support that may be due to loneliness and arround the half of the studied samples were single, so it can be said that people with higher social support enjoy more communication skill which direct them away from depression and other mental problems.

This result is in agreement with a cross sectional study conducted by **Eidelman, Gershon, Kaplan, McGlinchey and Harvey (2012)** that evaluated 35 individual with bipolar disorder in symptomatological remission and 38 healthy control. The result showed that bipolar disorder people had more deficit social support in comparison to control.

The present study showed that half of the studied sample who had low and moderate social support admitted to the hospital from 5 to 10 times and more and there was negative insignificant correlation between them that means that the lower social support patients have the higher number of hospital al admission patients will have .

In agreement with this research**, Weinstock and Miller (2010)** observed 92 bipolar disorder 1 clients over a span of one year to determine association among family function, support systems and functional impairment during the course of bipolar disorder. The results showed that low level of social support may place individuals with bipolar disorder at risk for subsequent depressive symptoms .

In the same line with this study**, Cohen, Hammen, Henry and Daley (2004)** research assessing 52 patients with bipolar disorder with one-year follow-up evaluating the impact of stressors and social support in the course of the condition study, found that increased stress levels and also reduced quality and availability of personal social connections indicate depressive relapse even under the care of the physician.

Conclusion

It can be concluded from the present study that low social support increased the risk for relapse among patients with bipolar disorder.

Recommendations:

According to the study finding , it is recommended that:

1- Planning and implementation of public health awareness programs to raise the orientation toward the nature of psychiatric disorders, these programs should reach all social classes and cultures in: schools, universities, social clubs, religious institutions and mass media.

2- Nurses and health care providers should be counseled and encouraged to participate in psycho-educational program to update their knowledge about mental health problems and its complication.

3-Training the medical team especially nursing staff on the importance of assessment of social support and the inclusion of assessment questionnaire in the record of patients with bipolar disorder .

4- Consider improvement social support as a basic element to prevent relapse among bipolar disorder patients.

5- Further research is needed to measure effect of social support on relapse prevention among bipolar patients.

References:

Beyer JL, Greenberg RL, Marino P, et al., (2014). Social support in late life mania: GERI-BD. *International Journal of Geriatric Psychiatry*, 29(10):1028–1032.

Bulechek GM et al., (2008): Nursing interventions classifications (NIC), ed 5, ST Louis, 2008, Mosby.

Cohen AN, Hammen C, Henry RM, Daley SE, (2004). Effects of stress and social support on recurrence in bipolar disorder. *Journal of Affective Disorders*;82(1):143-147.

Cutrona CE, Suhr JA, (1992). Controllability of stressful events andsatisfaction with spouse support behaviors. *Communication Research*, 19:154–174

Dixit S, Chauhan, VS, Azad S, (2015). Social Support and Treatment Outcome in Alcohol Dependence Syndrome . *Journal of Clinical and Diagnostic Research.* 2015 Nov, Vol-9(11): VC01-VC05.

Doherty , E.F & MacGeorge , E.L., (2012). Perceptions of Supportive Behavior by Young Adults With Bipolar Disorder Qualitative *Health Research ,* 23(3) :361–374.

Eidelman, P., Gershon, A., Kaplan, K., McGlinchey, E., Harvey, A. G (2012). Social support and social strain in interepisode bipolar disorder. *Bipolar Disorder*, 14, 628-640.

Gottlieb BH, Bergen AE (2010). Social support concepts and measures. *Journal of Psychosomatic Research,* 69:511–520.

Hsiu-Chia Ko, PhD, Li-Ling Wang, MS, and Yi-Ting Xu, MS,(2013). Understanding the Different Types of Social Support Offered by audience to A-List Diary-Like and Informative Bloggers. *CyberPsychology, Behavior, And Social Networking* ,Volume 16, Number 3, 2013

Koutra, K., Triliva, S., Roumeliotaki, T., Lionis, C., Vgontzas, A.N., (2015). Identifying the socio-demographic and clinical determinants of family functioning in Greek patients with psychosis. International *Journal of Social Psychiatry,* 61, 251–264.

MacGeorge, E. L., Feng, B., & Burleson, B. R. (2011). Supportive communication. In M. L. Knapp & J. A. Daly . Handbook of interpersonal communication (4th ed pp. 317-354). Thousand Oaks, CA: Sage.

Mehri, R., Kazarian, Sh. (2012). Validation of The Arabic Translation of the Multidimensional Scale of Perceived social support in a Lebanese Community Sample. *The Arab Journal of psychiatry*, 23(2), 159-168.

Oddone CG, Hybels CF, McQuoid DR, Steffens DC, (2011) Social support modifes the relationship between personality and depressive symptoms in older adults. *American Journal of Geriatric Psychiatry;*19(2):123-31.

Reinares, M., Bonnin, C.M., Hidalgo-Mazzei, D., Sanchez-Moreno, J., Colom, F., Vieta, E., (2016). The role of family interventions in bipolar disorder: a systematic review. *Clinical Psychology Review,*43, 47–57.

Sheri L. Johnson, Cuellar, A., Gershon, A., (2016). The Influence of Trauma, Life Events, and Social relationships on Bipolar Depression. *Psychiatric Clinics of North America,* 2016 March ; 39(1): 87–94.

Stuart GW.,(2013) . Principles and Practice of Psychiatric Nursing 10th edition**.** copy right 2013 by Mosby of Elsevier Inc**.** chapter 12 (Prevention and Mental health Promotion), pages 174-175.

Sullivan, A.E., Judd, C.M., Axelson, D.A., Miklowitz, D.J., (2012). Family functioning and the course of adolescent bipolar disorder. *Behavior Therapy,* 43, 837–847.

Toits, P. A. (2010). Stress and health: Major findings and policy implications. *Journal of Health and Social Behavior*, 51 (Special Issue), S41-S53.

Tommy, Ng & Johnson, SL. (2013). Rejection Sensitivity is Associated with Quality of Life, Psychosocial Outcome, and the Course of Depression in Euthymic Patients with Bipolar I Disorder. *Cognitive Therapy and Research*. 37. 10.1007/s10608-013-9552-1.

Weinstock, L.M., Miller, I.W., (2010). Psychosocial predictors of mood symptoms year after acute phase treatment of bipolar I disorder. *Comprehensive Psychiatry,* 51,497–503.

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*, 30-41.