Indian J. Psychiat., 1995, 37(3), 119-123.

SOCIAL SUPPORT AND PSYCHOSOCIAL DYSFUNCTION IN DEPRESSION

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Influence of social support on psychosocial dysfunction was studied in fifty newly diagnosed patients with major depression, using Social Support Scale (SSS) and Dysfunctional Analysis Questionnaire (DAQ) to measure social support and psychosocial dysfunction respectively. Total score on SSS did not affect the dysfunction. A positive relationship was observed between items of SSS relating to care, concern and expectations from others and negative relationship observed between SSS items referring to socialization and dysfunction in social and familial areas. The relationship of social support and psychosocial dysfunction appears quite complex with certain elements of social support having a healthy and others having an unhealthy relationship. Since measurement of social support itself is accompanied by a number of methodological problems such as distorted perceptions of psychiatric patients about social support, this makes the relationship more complex.

Key words: depression, psychosocial dysfunction, social support, outpatients.

INTRODUCTION

The term social support refers to the mechanisms by which interpersonal relationships protect people from deleterious effects of stress (Kessler, 1989). Social support has a very important role to play in maintaining an optimum level of efficiency and is necessary for feelings of physical as well as psychological well-being (Broadhead et al, 1983). A number of community surveys and case reports have shown that social support plays an important part in protecting against both onset as well as continuation of psychopathology (Kessler, 1989).

The term dysfunction refers to a change in reference to a particular period in the life of an individual. The functioning is compared with one's own previous level of functioning (Verma & Pershad, 1989). Psychosocial dysfunction is the dysfunction in various psychosocial areas such as personal, social, familial or occupational. Various psychiatric disorders are associated with varying degrees of psychosocial dysfunction.

Since social support has been found to influence the onset as well as continuation of psychopathology and hence also the regaining of premorbid functioning status, it would also be expected to influence the psychosocial dysfunction secondary to the illness. Depression would be an ideal illness to study such a relationship, since lack of social support has been reported to be a risk factor for depression (Rabkin & Streuning, 1976; Henderson et al, 1981; Koenig et al, 1991; Booth et al, 1992). Social support and depression appear to be inversely related (McNaughton et al, 1992; Steinglass et al, 1988).

Lack of social support or even lack of its perception have been found to be related to severity (Booth et al, 1992) and duration of depression (Morris et al, 1991). The subjective perception of social support and depressive symptoms, though interrelated, are separate constructs (Blazer & Hughes, 1991). The current study was undertaken to assess whether the extent or quality of social support available has any relation to the dysfunction experienced by patients with depression.

MATERIAL AND METHODS

The study was done is University College of Medical Sciences and Guru Teg Bahadur Hospital, Shahdara, Delhi. Colleagues in the department were requested to refer to the author all new patients with diagnosis of major depression (DSM III-R) without any psychotic features. The decision to include only patients without psychotic features was taken to exclude the effect of psychosis on the assessment of social support and to make the sample homogeneous. Detailed psychiatric evaluation of these patients was done to further confirm the diagnosis for the purpose of study. Only patients who were not on any psychotropic drugs at the time of evaluation were taken for the study. This was done to exclude the effects of treatment on ratings. Informed consent was taken from all patients.

Dysfunction was assessed on Dysfunctional Analysis Questionnaire (DAQ; Pershad et al, 1985) by the author himself. Assessment of social support was done by a psychiatrist colleague blind to the dysfunction ratings, using the Hindi adaptation of Social Support Scale (SSS; Nehra & Kulhara, 1987).

A brief introduction of the instruments is given below:

1. Dysfunctional Analysis Questionnaire [DAQ]:

DAQ is a fifty item questionnaire in Hindi, developed and standardized in India (Pershad et al, 1983 & 1985), which measures dysfunction in five areas of activity, i.e. social, vocational, personal, familial and cognitive. The instrument can be either self administered or administered in a structured clinical interview. There are ten items each for the above mentioned five areas of activity. Each item is rated on a five point scale (1-5), comparing the present level of functioning to that before the onset of illness. A score of 1 indicates functioning better than that before the onset of illness, 2 indicating no impairment and 3, 4, and 5 indicating mild, moderate and severe impairment respectively. The total score for each of the activity areas is converted to a percentage score, which has a range of 20 to 100. A score of 20-39 indicates better functioning than premorbid level, 40 indicates no change and a score of more than 40 is an indication of dysfunction. DAQ has been used by a number of research workers and found useful to assess dysfunction (Chavan & Kulhara, 1988; Varma et al, 1987; Chadda et al, 1993).

2. Social Support Scale - Hindi adaptation [SSS]:

The Hindi adaptation of SSS (Nehra & Kulhara, 1987; Pollack & Harris, 1983) is a sixteen item self administered questionnaire. The items refer to help, support, concern, reinforcement and criticism which a person gets from his or her family, friends, social acquaintances and working colleagues. In addition, there are certain general statements, such as 'Good friends are difficult to find' and 'It is better to say what others want to listen.' Seven items of the scale are positively worded and nine are negatively worded. Each item has four options ranging from no agreement (scored as 1) to extreme agreement (scored as 4). A higher score indicates that more support is available to the individual. The Hindi adaptation has been found to have superior test-retest reliability and stability than the Hindi translation of the original scale of Pollack and Harris (1987).

Analysis:

Data was analyzed to study whether the dysfunction on various subscales of DAQ is affected by the degree of social support available.

RESULTS

The sample consisted of fifty patients, twenty nine females and twenty one males. Mean age was 37.4 (range 17-68) years. Most (94%) patients were married. The mean scores on various subscales of DAQ were 65.5 (social), 63.5 (vocational), 65.8 (personal), 61.4 (familial) and 46.3 (cognitive). Mean score on SSS was 40.3. Linear regression analysis of DAQ subscale scores on SSS scores did not show any significant results (Table 1).

Table 1
Regression analysis of DAQ Scores on SSS Scores (n=50)

Dependent variable (DAQ subscale)	Mean score on DAQ sub-scales	SSS score	Significance
Social	65.5 (13.5)	40.3 (2.3)	p>0.15
Vocational	63.5 (11.3)	40.3 (2.3)	p>0.10
Personal	65.8 (9.8)	40.3 (2.3)	p>0.25
Familial	61.4 (13.6)	40.3 (2.3)	p>0.20
Cognitive	46.3 (4.2)	40.3 (2.3)	p>0.70

Figures in parentheses indicate standard deviations.

Since total SSS scores were found not to affect the DAQ scores, an attempt was made to find out if the dysfunction scores could be linearly influenced by some item groups of SSS. Therefore, SSS items were subjected to cluster analysis. Five clusters of items emerged. Clusters 1 and 4 were formed by five items each, cluster 3 contained three items, cluster two contained 2 items and cluster five consisted of only 1 item. Linear regression was worked out to study the relationship between scores on SSS clusters and DAQ subscale scores.

Table 2 shows scores on various SSS clusters and the results of linear regression analysis. A significant positive relationship was observed between scores on cluster 1 and dysfunction on vocational, personal and familial subscales of DAQ (higher the scores on social support items, more severe was the dysfunction). Significant negative relationship was found between scores on cluster 5, i.e. item No. 13 and dysfunction scores on familial and social subscales. Scores on clusters 2, 3 and 4 did not significantly affect the dysfunction scores.

Table 2
Regression of DAQ Scores on SSS Scores (n=50)

Regressed on (SSS clusters)	Dependent Variable (DAQ sub-scales)	Linear Regression Equation #	Significance (t test)
Cluster 1 13.5(2.2)*	Social		p>0.10
	Vocational	V=1.8 C11 + 39.7**	p<0.02**
	Personal	P=1.3 C11 + 47.7**	p<0.03**
	Familial	F=2.1 C11 + 33.1**	p<0.02**
	Cognitive		p>0.40
Cluster 2 5.0 (1.0)*	Social		p>0.70
	Vocational		p>0.60
	Personal		p>0.70
	Familial		p>0.80
	Cognitive		p>0.40
Cluster 3 8.6 (1.6)*	Social		p>0.30
	Vocational		p>0.10
	Personal		p>0.40
	Familial		p>0.10
	Cognitive		p>0.60
Cluster 4 11.3 (2.5)*	Social		p>0.80
	Vocational		p>0.20
	Personal		p>0.30
	Familial		p>0.10
	Cognitive		p>0.80
Cluster 5 1.9 (0.7)*	Social	S=7.1 C15 + 79.0**	p<0.006**
	Vocational		p>0.06
	Personal		p>0.07
	Familial	F=6.9 C15 + 74.5**	p<0.008**
	Cognitive		p>0.70

V,P,F and S indicate Vocational, Personal, Familial and Social respectively; C11 and C15 indicate cluster 1 and 5 respectively;

* Mean scores on various SSS clusters; Figures in parentheses indicate standard deviations.

** indicate significant associations.

DISCUSSION

The findings of the present work were unexpected as no significant relationship was observed between social support and psychosocial dysfunction. Certain components of social support such as care, concern and expectation from relations and friends and difficulty in getting trustworthy persons (items of cluster 1 of SSS) were found to have a positive relationship with dysfunction in personal, familial and vocational areas. Thus, depressive patients who get more support in the form of care and concern and have higher expectations from their family and social circle are likely to show more psychosocial dysfunction. Such a care or concern may interfere in the making of active efforts by the individual to resume premorbid functioning. The finding has therapeutic implications in that depressed patients should be encouraged to actively resume functioning rather than providing only care and concern.

Components of social support such as feeling better on discussing problems with other (cluster 5 of SSS) were found to have a negative relationship with social support. Thus, persons who feel better on discussing about their problems with others, in other words, who feel better on socializing (a reactive feature also indicating lesser severity of illness), suffer from lesser dysfunction in social and familial areas. Other clusters of social support on SSS, which were not found to affect the dysfunction, referred to the availability of help from home or office, getting praise and regard for being good at work, unnecessary criticisms, feelings of loneliness in social gatherings and lack of confident relationships. It is difficult to explain these findings.

Subjective perceptions of social support can be influenced by personality, mood and the illness status of an individual (Alloway & Bebbington, 1987). Presence of psychiatric symptoms may itself impair an individual's capacity to establish and maintain interpersonal relationships (Henderson, 1977) and hence social support. These factors, some of which are difficult to control, make assessment of social support in psychiatric patients more complicated (O'Reilly, 1988). This methodological flaw could have affected the observations in the present study.

Social support appears to have both positive as well as negative components. Positive or helpful components have been reported to lower depression. Negative components such as distorted or conflictual interactions between psychiatrically impaired individuals and their social networks may act as risk factors in the onset and prolongation of the psychiatric disorder (Kessler, 1989). These are also responsible for increased severity of illness (Revenson et al, 1991) and hence, increased dysfunction. Negative social interactions have been found to be more strongly related to mental health components compared with positive interactions (Kessler, 1989). One should consider both positive as well as negative aspects of support transactions conjointly in assessing their stress reducing and health protective potentials.

There were also certain limitations in this study, being its cross-sectional nature and the inability to control the influence of distorted perceptions on the assessment of social support, which could have affected the results. It has been reported often that it is the perception of quality of social support that bears a relationship with the illness (Blazer & Hughes, 1991; Morris et al, 1991), and hence also dysfunction. This covers one of the limitations.

To conclude, the current study suggests that social support and dysfunction have a complex relationship, with certain components of social support showing positive, some showing negative and others showing a neutral relationship. Considering the complicated nature of the relationship between social support, psychiatric disorders and the accompanying dysfunction there is a need for prospective longitudinal studies, taking care to minimize the methodological problems associated with measurement of social support.

ACKNOWLEDGEMENTS

The author is grateful to Dr. K.N. Thakur (formerly senior resident in the department for help in data collection) and to the Computer Center, University College of Medical Sciences, Delhi for data analysis.

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