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A study on resilience and social support in bipolar affective disorder patients in remission visiting a tertiary care centre

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Abstract
Introduction: Bipolar affective disorder is one of the most complex psychiatric conditions characterized by recurrent mood episodes and longitudinally varied courses. It affects at least 1% of the population. Even though it is an episodic illness patients face many challenges during inter episodic period. The study aims to investigate social support by BPAD patients in remission and how it affect the resilience in them.
Methodology: Cross sectional study.275 BPAD patients in remission were evaluated using semi-structured socio demographic perfoma, Connor-Davidson Resilience 25 item scale and Multidimensional Scale of Perceived Social Support
Result: Study showed majority of the patients had moderate resilience. Patients had highest support from family and lowest support from friends.
There was significant association between perceived social support and resilience in. the patients of BPAD.
Conclusion: Higher perceived social support enhance resilience in patients of bipolar affective disorder.

Keywords: Bipolar affective disorder, resilience, social support

Introduction

Bipolar affective disorder is one of the most complex psychiatric conditions characterized by recurrent mood episodes and longitudinally varied courses. It affects at least 1% of the population [1]. Bipolar disorder (BD) remains one of the mental disorders with the greatest global burden in spite of the therapeutic advances made to the date. According to the World Health Organization (WHO), BPAD is the sixth leading cause of disability among illnesses worldwide [2]. The traditionally accepted clinical conception of the course of BPAD is that it is marked by time-limited acute episodes of mania and major depression, with occasional hypomanic and mixed episodes, with recovery back to euthymia. The classical concept also suggests favorable functional adaptation between episodes, with a marked decrease in acute morbidity with effective mood-stabilizing treatments [3].
However, a number of recent studies have indicated that several patients with BPAD, who no longer met the syndromal or symptomatic criteria following recovery from an acute affective episode, nevertheless continue to display functional impairment [4]. It Is important to follow up with subjects over many years to study the phenomenology of episodes given that bipolar I disorder has a mean age at onset of 18.2 years and the risk of having mood episodes remains relatively high for at least 40 years
Human beings are social animals. Each person living in the society is part of a different group from family to various cultural religious linguistic groups. Social interaction forms the backbone of the society. Cobb (1976) defined “social support as information leading the subject to believe that he or she is loved, esteemed, and belongs to a network of mutual obligation” social support includes the support which is taken from family, friends, neighbours and institutions which enhance the psychological dynamics, and help the individual in the aspects of affective, physical, cognitive contribution [6]. Social support was defined by Thoits [5] as helpful actions performed for an individual by significant others, such as family members, friends, and co-workers.

There are different classification of social support the most commonly used is perceived social support and received social support [6]. Perceived support refers to a recipient's subjective judgment that providers will offer or have offered effective help during times of need. Received support also called enacted support refers to specific supportive actions (e.g., advice or reassurance) offered by providers during times of need [7].

There are four common functions of social support. Emotional support is the offering of empathy, concern, affection, love, trust, acceptance, intimacy, encouragement, or caring. Tangible support also known as instrumental support the provision of financial assistance, material goods, or services [8]. Informational support is the provision of advice, guidance, suggestions, or useful information to someone [9]. Companionship support also known as esteem support or appraisal support is the type of support that gives someone a sense of social belonging [9]. Reduced social support can be a psychosocial stressor according to many studies [10]. Insufficient social support contributes to incomplete recovery, a chronic course of illness long duration of hospital stay and more financial burden. The research on social support in bipolar disorder has been rather limited and has produced somewhat contradictory results. A study done by Romans and McPherson found that bipolar subjects had lower scores on perceived availability and adequacy of both intimate and diffuse social relationships. Resilience is defined the ability to successfully withstand a threatening and challenging situation. According to Agaibi and Wilson, 2005, it means being competent in response to the demands imposed on the ability to cope [11]. According to Werner, it is defined as successful adaptation following exposure to stressful life events and an individual’s capacity for transformation [12].

Few studies have evaluated social support in Bipolar Affective Disorder patients but no studies have specifically examined resilience and perceived social support in Bipolar Affective Disorder patients in remission. Hence the present study is undertaken to explore these aspects.

Aims and Objectives

1. To study the social support in Bipolar affective disorder patients in remission
2. To study the resilience in Bipolar affective disorder in remission.
3. To study the relationship between social support and quality of life

Methodology

Methodology study setting

Study was conducted at tertiary care centre for mentally ill in the city of Warangal, Telangana state.

Sampling

Sampling was done by a convenient sampling method because of feasibility of the method in obtaining sample whenever patients come outpatient review.

275 patients with BPAD in remission were selected.

Study design

- Cross sectional study.
- As the study intends to assess said variables at one point of time by asking about their experiences in last one month, this design has been adopted.

Study period

The study was conducted for 8 between December 2021 and May 2022

Inclusion criteria

1. Age of the subjects between 18-65 years.
2. Male and female genders.
3. Patients who meet the ICD 10 criteria for BPAD and who score<8 in HAM-D scale and <YMRS scale were taken up for the study.
4. Subjects willing to participate in the study and give written informed consent.

Exclusion criteria

1. Subjects with primary organic illness.
2. Subjects with mental retardation.
3. Subjects with chronic debilitating medical illness.
4. Subjects with psychoactive substance abuse or dependence according to ICD 10 excluding nicotine
5. Subjects not willing to give written informed consent.

Study procedure

- Institutional ethics committee clearance was obtained prior to the start of the study.
- A consecutive, convenient sample of 275 persons with BPAD in remission were taken from those attending outpatient service.
- Participants were explained the procedure and those who were willing to give written informed consent were only taken up for the study.
- Subjects were taken up only after a thorough assessment of inclusion and exclusion criteria.
- On first contact with the subjects, a questionnaire was administered which collected sample sociodemographic details like name, age, gender, religion, domicile, education levels, occupational background, marital status, socio economic status, and also clinical details like duration of illness,.
- Later, Hamilton’s depression scale and Young’s mania scale were administered and those who score<8 in HAM-D and<12 in YMRS were selected.
- Subjects were given two other scales i.e., Multidimensional perceived social support scale to measure the social support and Conner’s resilience scale.
- These scales were administered privately, separate from patients as it might contain sensitive questions and this was to make them comfortable while answering such questions.
- This data was later compiled and analysed using SPSS software.

Scales Used

Resilience

Resilience was measured with the Connor-Davidson Resilience 25 item scale. This is a self-report scale ad consists of 25 items. Respondents rate the item on a scale of 0 to 4.The higher score reflect higher resilience. In the present study the score was calculated as follows: less than 50% indicates mild level of resilience, score of 50-75 indicates moderate levels of resilience and score greater than 75% indicates high resilience [13].

Multidimensional Scale of Perceived Social Support
The scale was developed by Zimet *et al.* in 1988. The scale consist of a total of 12 items. Each items are rated in a 7 point Likert -type scale (1-7 points) ranging from absolutely no to absolutely yes. The scale has three sub scale to determine the support of family, friends and special person. The lowest and highest scores obtained from the sub scales are 4 and 28 respectively. Total score is ranging from 12 to 84.Scale was tested for internal consistency. Cronbach's alpha values were 0.85, 0.88, 0.92 for the family sub scale, friend sub scale and other significant person sub scale respectively [14].

Result
Table 1 shows the socio demographic parameters.275 BPAD patients in remission participated in the study. 52.5% of patients were females. Majority of the care takers (39.5%) completed middle school and majority were married. Most of the participants belonged to upper lower socio-economic class according to modified Kuppuswamy classification. Most of the care taker were either unskilled (26.1%) or semiskilled workers (44%).

Resilience
Table 3 shows resilience in the participants 44.6%o the participants had moderate resilience, 26.7% had low resilience where as28.7% had high resilience. There was no significant association between resilience and any of the socio demographic parameters.

Perceived social support.
Table 2 shows mean perceived social support scores. Mean family support was found to be highest (21.22+/-4.5) followed by private person (16.24+/-7.3). Support from friends were found to be lowest. (7.11+/-3.4).There was significant association between education and total perceived social support (F=4.18 P=0.04) and between socio economic status and total perceived social support (F=2.28 P=0.02).

Table 1: Sociodemographic variables.

Frequency%(n)	
Gender	
Male	47.1 (130)
Female	52.5(145)
Education	
Uneducated	10.9(30)
Primary school	9.5(26)
Middle school	39.5(119)
High school	9.8(27)
Intermediate	16.5(50)
Graduate	2.9(8)
Marital status	
Married	72.7(183)
Single	9.8(27)
Divorced	11.1(30)
Widow	6.4(17.6)
Domicile	
Rural	48.1(130)
Urban	52.4(145)
Religion	
Hindu	76.8(212)
Muslim	18.5(51)
Christian	4.3(12)
Socioeconomic status	
Lower	9.1(25)
Upper lower	49.3(136)
Lower middle	18.8(52)
Upper middle	18.5(51)
Upper	4(11)
Employment	
Unemployed	15.9(45)
Unskilled	26.1(73)
Semiskilled	44(125)
Skilled	11(31)

Table 2: Perceived social support scores

Scales	Subscales	Mean+/-SD
Perceived social support	Family support	21.22+/-4.5
	Friend support	7.11+/-3.4
	Other significant support	16.24+/-7.3
	Total social support	47.34+/-12.33

Table 3: Resilience score

Scale		Mean +/- SD	Frequency (n)
Resilience score	Low resilience	44+/-13.6	73
	Moderate resilience	61+/-14.6	124
	High resilience	76+/-13.5	78

Table 4: Correlation between family support and resilience

Correlation	Spearman Correlation Coefficient	P Value
Family SUP vs Resilience	0.4	<0.001

There was a moderate positive correlation between Family support and Resilience, and this correlation was statistically significant (rho = 0.44, p = <0.001).

Table 5: Correlation between Friend Support and Resilience (n = 513)

Correlation	Spearman Correlation Coefficient	P Value
Friend Support vs Resilience	0.6	<0.001

There was a strong positive correlation between Friend Support and Resilience, and this correlation was statistically significant (rho = 0.61, p = <0.001).

Table 6: Correlation between OP Support and Resilience (n = 513)

Correlation	Spearman Correlation Coefficient	P Value
OP Support vs Resilience	0.7	<0.001

There was a strong positive correlation between OP Support and Resilience, and this correlation was statistically significant (rho = 0.73, p = <0.001).

Discussion

The present study focused the association between resilience and perceived social support in BPAD patients in re3mission. Our study which showed 44.6% had moderate resilience 26.7% had mild resilience where as28.7% had high resilience. Our study also paticipants showed highest perceived support from family and lowest from friends. This is in contrast with another study done by Sahar Mahmoud in 2018, which assessed resilience in caregivers using Family resilience assessment scale and found that 53.6 % had low family resilience, 30.9% had moderate resilience and 15.5% had high family resilience [15]. This observed difference could be due to use of a different instrument which measures collective resilience in the family while the present study analysed individual or personal resilience which could vary from family resilience. This is also supported by another study conducted by Marsh *et al.* which reported high personal resilience (99%) followed by family resilience (88%) and consumer resilience (76%). Another Indian study conducted by Herbert HS, Manjula M *et al.*, which studied the concept of resilience and factors contributing to it among the off springs of parents with schizophrenia. This study stated that resilience did not depend on any socio demographic/ clinical variables which is in par with our study.

A cross sectional study done by Wilkins *et al.* in 2003 also showed that BPAD patients have low social support especially from friends but study differs from present study in methodological aspect as it used Medical Outcome Social Support Scale (MOSSS) to assess social support in BPAD patients [16]. A study by Eildelman *et al.* in 2003 also showed BD patients have more deficient social support compared to [17] In contrast to present study Staner *et al.* in 1997 showed that Social support is unable to predict new episodes in this sample [19] It is not a major factor in the recovery of the individual. This can be attributed to low sample size of the study as the study took only 26 remitted BPAD patients to study the effect of social support. Many literature has shown positive associations between poor social support and physical and mental health and identified potential mechanisms for these associations. [20].

The present study showed increased perceived social support enhances the resilience of the BPAD patients. In par with our study, a study done by Lauren *et al.* in trauma exposed individuals showed enhanced resilience From the observations in the current study [19], it can also be concluded that resilience has a positive role in increasing overall positive emotions, improved interpersonal relationships which leads to improved social functioning. Our study has certain limitation. This is a single centred study and generalisation of results requires further multi centred research. Since this is cross sectional study causal inferences cannot be made. Hence follow up studies are required.

Conclusion

There is significant association between resilience and perceived social support in patients of bipolar affective disorder. We recommended psycho educational interventional programmes in the community level which help to increase resilience in BPAD patients. Such programmes also decrease the stigma which in turn increases the social support to the patients.

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