

Perceived social support and quality of life among persons with bipolar affective disorders and alcohol dependence: A comparative study

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ABSTRACT

Background: Bipolar affective disorders (BPAD) and Alcohol dependence syndrome (ADS) are globally found in the general population. These disorders are characterized by similar dysfunction in families like inadequate support system and poor quality of life. **Aim:** This study aims to explore the perceived social support and quality of life of the person diagnosed with BPAD and ADS (ICD- 10 DCR) and find out its relationship with socio-demographic variables. **Methods:** This research study was done at the inpatient and outpatient department of Ranchi Institute of Neuropsychiatry and Allied Sciences (RINPAS), Kanke, Ranchi and data was collected by the purposive sampling technique from RINPAS, Ranchi. The sample consisted of 60 subjects, equally divided BPAD and ADS (subjects diagnosed as per ICD- 10 DCR). A Socio-demographical Data-sheet, Multidimensional Perceived Social Support (MSPPS) and Quality of life scales were used in the study. **Result:** The result shows that the mean age of the participants was 30.36±6.84 years for BPAD and 32.40±5.73 years for ADS. Also, the study found that participants of ADS had poor quality of life ($p<.001$). **Conclusion:** The study indicates that the severity of Alcohol dependence syndrome affects individual quality of life. The study found that perceived social support is also affected similarly in both the disorders BPAD and ADS.

Keywords: Bipolar affective disorder, alcohol dependence syndrome, perceived social support

INTRODUCTION

Bipolar Affective Disorder (BPAD) is a fascinating but tragic psychiatric condition. According to the National Mental Health Survey (2016), mood (affective) disorder lifetime prevalence rate is 5.6% & current rate is 2.8%.¹ Bipolar Affective disorder has a mixed affect state, where the symptoms of both mania and depression, occur at the same time. In a state of mania or depression, people can also experience psychotic symptoms. BPAD is ranked as the sixth leading cause of disability, across physical and psychiatric disorders.² In BPAD social support is powerfully nexus with morbidity and mortality.³ The relationship between alcohol consumption and perceived

social support is complex; perhaps even more so among those with severe AUD.⁴ According to Brown and his colleagues says that when an individual experiences a severe event without support confidence has a 40% of developing depression, in contrast, those with confidence have a 4% risk.⁵

According to a short textbook of psychiatry written by Ahuja found that alcohol dependence was previously called as alcoholism but due to its derogative meaning the term like addiction has been dropped.⁶ In ICD-10, dependence syndrome comes along with physiological, behavioural and cognitive processes the use of substances on a much higher priority for a given individual than other behaviours that once has greater value.⁷

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Alcohol consumption is one of the common behavioural disorders. Research suggests that Alcohol consumption and related problems are rising in India every day and constitute a public health crisis⁹ by its magnitude and consequences to social, political and economic health. In India alcohol-related morbidity and mortality of 39.1 and 41 lakh population males due to cirrhosis and road traffic accidents, according to the global status report on alcohol, 2014.¹⁰ Balan says that 50% of psychiatric illnesses are caused due to drinking alcohol.¹¹

Alcohol abuse is one of the major public health concerns in India. Recent literature suggested studies to confine the "emerging problem" of alcohol dependence in the country. One recent study has also stated that dramatic increase in alcohol consumption over the past three decades.^{12,13}

Social support is defined as access to a relationship that meets fundamental interpersonal needs.¹⁴ Caplan defined social support as information leading to an individual to believe that he or she is cared for, loved and esteemed, and is a member of a network of mutual obligation.¹⁵ Perceived social support has been defined as an individual's cognitive appraisal of being reliably connected to others.¹⁶ Turner views perceived social support as providing a basis for identifying the behaviour and circumstances of a particular person.¹⁷ Perceived social support does not involve any receiving tangible support or assistance but it is a perception that support is available during times of stress.¹⁸

This study aims to assess the perceived social support and quality of life of the person diagnosed with BPAD and ADS and find out its relationship with socio-demographic variables.

METHODOLOGY

The research study was completed at the inpatient and outpatient department of Ranchi Institute of Neuropsychiatry and Allied Science Kanke, Ranchi (RINPAS) India. Ethical permission was taken from the Institute Ethics Committee to conduct research work. The study was hospital-based cross-sectional and used purposive sampling methods for data collection. Duration of the study three months this study has two groups of participants, persons with Bipolar Affective Disorder and Alcohol dependence. The total sample was 60

and equally divided from each group according to ICD-10 DCR criteria.⁷ Male participants age range of 20 to 45 years and those who gave written informed consent were included in the study. Participants having co-morbidity of any severe physical illness other than BPAD and ADS were excluded from the study. Tools used in the study self-prepared checklist socio-demographic and clinical data sheet, it was consisting of information on age, education, occupation, marital status, religion, types of family, domicile, and socio-economic status. Multidimensional Scale of Perceived Social Support (MSPSS Adopted for Indian Population): This scale has been designed by Zimet et al.¹⁹ This scale is a brief research tool to measure the perceptions of support from 3 sources: Family, (FA) Friends, (FR), and Significant Other (SO) total 12 items and divided into three equal groups. MSPSS has excellent internal consistency and test-retest reliability (non-clinical samples 0.81 to 0.98 and in clinical samples 0.92 to 0.94). [Hindi adoption] Quality of Life Scale (BREF).²⁰ Statistical analysis will be carried out by Statistical Package for the Social Sciences (SPSS), 16th Version.

RESULT

Table 1 (a) shows the socio-demographic variable comparison of the patient's education, marital status, religion, category, residence, family income types of family and parents' occupation between Bipolar Affective Disorder (BAD) and Alcohol Dependence Syndrome (ADS). Most of the respondents were educated up to intermediate and above (60.00% and 63.30%). There was no significant difference between groups.

As per socio-demographic details, the result indicated that almost (60.0%) of individuals with bipolar affective disorder and (63.3%) of individuals with alcohol dependence were educated at 12th standard respectively. However, the majority of the patients with bipolar affective disorder (53.3%) were unmarried and patients with alcohol dependence (56.7%) were married in the present study. However, there were significant differences found in family income, parent's occupation and category between both groups. While no significant differences were found in other socio-demographic variables of both groups.

Table 1 (a): Socio-demographical characteristics of the patients (n=60)

Variable		Groups		χ^2	p
		BPAD	ADS		
		N = 30	N = 30		
Marital Status	Unmarried	16 ± 53.3	13 ± 43.3	.606	.152
	Married	14 ± 46.7	17 ± 56.7		
Category	Gen	4 ± 13.3	7 ± 23.3	13.138	.003*
	OBC	21 ± 70.0	9 ± 30.0		
	SC	3 ± 10.0	2 ± 6.7		
	ST	2 ± 6.7	12 ± 40.0		
Residence	Rural	19 ± 63.3	9 ± 30.0	6.709	.035
	Urban	5 ± 16.7	10 ± 33.3		
	Semi-Urban	6 ± 20.0	11 ± 36.7		
Type of Family	Nuclear	22 ± 73.3	25 ± 83.3	.884	.347
	Joint	8 ± 26.7	5 ± 16.7		

*p<0.1

Table 1 (b): Socio-demographical characteristics of the patients (n=60)

Variable	Group		t (df= 58)	P
	BPAD	ADS		
	Mean ± SD	Mean ± SD		
Age	30.36 ± 6.84	32.40 ± 5.73	1.247	0.217

Table 2: Compression of Multidimensional Perceived Social Support among Bipolar Affective Disorder (BPAD) and Alcohol Dependence Syndrome (ADS)

Variables	Groups (n=60)		t (df=58)	p
	BPAD	ADS		
	Mean ± SD	Mean ± SD		
Significant others Subscale (SO)	15.96 ± 6.04	13.36 ± 5.35	1.762	.083
Family subscale (FS1)	16.23 ± 5.78	16.23 ± 5.78	1.832	.072
Friends subscale (FS2)	17.96 ± 5.28	18.50 ± 22.57	-.126	.900

Table 3: Comparison of scores of WHOQOL between Bipolar Affective Disorder (BPAD) and Alcohol Dependence Syndrome (ADS) Groups

QOL Domains	Groups		t(df=58)	p
	BPAD	ADS		
	Mean ±S.D.	Mean ±S.D.		
Physical	21.50 ± 392	17.13 ± 2.28	5.26	.000**
Psychological	16.60 ± 3.12	13.56 ± 1.71	4.56	.000**
Social-Relation	24.46 ± 2.76	19.03 ± 2.28	8.30	.000**
Environmental	8.86 ± 2.41	8.53 ± 2.14	.56	.574

**p<0.001

Table 2 shows the result of the multidimensional perceived social support compression between groups of BAD and ADS, Significant others Subscale (SO) shows the mean and standard deviation BAD patients are (15.96 ± 6.04) and ADS patients are (13.36 ± 5.35), Family subscale (FS1) show the mean and standard

deviation BAD patients are (16.23 ± 5.78) and ADS patients are (16.23 ± 5.78), Friends subscale(FS2) show the mean and standard deviation BAD patients are (17.96 ± 5.28) and ADS patients are (18.50 ± 22.57). There were no significant differences found in both groups.

Table 3 shows a comparison between the participants of BPAD and ADS in various domains of WHOQOL BREF i.e., physical, psychological, social relation and environmental quality of life. Results found that highly significant physical, psychological and social domains at ($p < .001$) level. Participants of ADS had having poor quality of life compared with those with BPAD.

DISCUSSION

The present study included male patients only with BPAD and ADS while other studies have taken both the gender of the patients with BPAD and ADS²¹ and perceived social support from friends, families and others were positively and significantly related to individual coping abilities, quality of life and functioning.²² In this study assess perceived social support by a multidimensional scale of perceived social Support (MSPSS).

As per socio-demographic details, the result indicated that almost (60.0%) of individuals with bipolar affective disorder and (63.3%) of individuals with alcohol dependence were educated at 12th standard respectively. However, the majority of the patients with bipolar affective disorder (53.3%) were unmarried and patients with alcohol dependence (56.7%) were married in the present study. However, there were significant differences found in family income and category between both groups. While no significant differences were found in other socio-demographic variables of both groups. It was found that excessive partner alcohol use increased the risk for coping, poor quality of life and lack of social support above and beyond significant socio-demographic risk factors including older age, poor education and lack of paid employment. Previous researchers have found similar finding which is incorporated into the present study.²³

Very less studies presented a comparison of perceived social support and quality of life among persons with BPAD and ADS but many research studies support significantly lower social support in persons with BPAD full recovery ($p = 0.003$)²⁴ and also one study found that drug addicts persons were found to have a lower score in social support.²⁵ In the present study after a comparison of perceived social support among persons with BPAD and ADS was found that no significant difference on

various domains of multidimensional perceived social support. Literature suggests that support system reflected that it helps to overcome stressful situation and improves interpersonal relationship. Researchers noted that support systems decreased the adverse psychosocial impact or exposure to stressful conditions and ongoing life strains.^{26, 27} The Impact of support systems on connected to health and disease, as well as the helpful effect on the development of illnesses such as diabetes and depression.^{28, 29}

Support systems indicate that the availability of family members, friends around us on whom individuals can depend and caregivers who reciprocate our values, Love and affection. A support system reinforces the ability to endure stress and overcome frustration.³⁰

Literature suggested in the field of support systems in alcohol intake and bipolar affective disorders have a wider role in understanding risk factors related to alcohol dependence syndrome and wider suggestions in improving treatment response for controlling relapses. The support system is one of the psychosocial management variables.^{31, 32}

The present study found that significant difference among BPAD and ADS in quality-of-life domains Individuals with bipolar affective disorder have a better quality of life compared with individuals with alcohol dependence. The lack of study in comparison to perceived social support among person with BPAD and ADS were found. The previous finding has been supported by the present study and the majority of the studies we identified indicated that QOL is markedly impaired in patients with alcohol dependence as compared to bipolar disorder.³³

Limitation of the study: Study results cannot be generalized whole country (India) as the sample was restricted only to one state.

CONCLUSION

Social Support and quality of life are the most important areas for individuals day to life who suffering from any kind of psychiatric illness. A study was conducted between two major psychiatric disorders bipolar affective disorders and alcohol dependence syndrome. The study indicates that the severity of Alcohol dependence syndrome affected individual quality of life found poor due to the psychopathology and nature of illness. The

study found that perceived social support of also affected equally in both the disorders BPAD and ADS due to similar symptoms and family dysfunction were present.

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