

Impact of Perceived Social Support on Quality of Life in Patients with Obsessive Compulsive Disorder

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Abstract: ***Background:** Numerous studies indicate perceived social support is essential for maintaining quality of life in patients with Obsessive-compulsive disorder. **Objective:** The study examines the role of perceived social support in quality of life (QOL) of patients with OCD. **Methods:** Fifty patients (25 females, 25 males) between 21 and 65 years old with OCD were recruited from the outpatient psychiatric units of different hospitals of Kashmir Valley. Quality of life was assessed by means of the WHOQOL-BREF, a self-administered questionnaire developed by WHO. Perceived Social Support was assessed by using Multidimensional Scale of Perceived Social Support (MSPSS). **Results:** The results show a significant relationship between social support and quality of life. The findings of the study revealed that family support and support from friends were found significant predictors of quality of life among obsessive-compulsive disorder patients. Implications of present findings for OCD patients are discussed.*

Keywords: Obsessive-compulsive disorder; Perceived social support; Quality of life

1. Introduction

Since decades, social scientists have shown great interest in the phenomena of social support, particularly in the context of quality of life. Previous research has found that those with high social networks have a decreased risk of mortality and improves quality of life in comparison to those who have poor social relationships, even after statistically controlling for baseline health status (Berkman et al., 2000). Current research has focused on expanding the role of perceived social support on quality of life in patients with OCD as there is a dearth of psychological research on perceived social support and quality of life in Obsessive-compulsive disorder patients

Social support is a multifaceted experience that involves voluntary union and formal and informal relationships with others (Bardach, et al., 2011). It is a perception that one is accepted, cared for, and provided with assistance from certain individuals or a specific group or the realization of actual support received from another. Social support can be positive or negative and can be received from different sources, including family members, friends, and peers (informal support) and healthcare professionals and organizations (formal support) (van Dam HA, et al., 2004). It can be perceived differently on the basis of the recipient's gender, racial or ethnic background, or cultural practices. It is a construct thought to mediate improved self-management practices and health care outcomes. In contrast, social networks are considered webs of social relationships and social linkages and must be distinguished from social support (van Dam HA, et al., 2004). Social networks are best gauged by size and include all individuals in a person's environment who provide support (van Dam HA, et al., 2004). Social support has been described as "support

accessible to an individual through social ties to other individuals, groups, and the larger community.

Several studies has investigated the relationship between social support and quality of life (Cohen et al. 1985; Holahan et al. 1997; Schwarzer & Leppin 1989). Previous researches has demonstrated that heightened social support can improve the QOL of persons with mental illness (Rudnick & Kravetz, 2001; Yanos et al., 2001; Nelson et al., 1995). Social support buffers against stressful life events, increases adherence to medical treatments, and improves recovery from medical illness, among other health-promoting effects (Cohen & Hoberman 1983; Cohen et al. 1985; DiMatteo 2004; Heaney & Israel 1997; Sarason et al., 1997). For people with severe mental illness, perceptions of adequate social support are associated with several psychological benefits, including increased self-esteem, feelings of empowerment, functioning, quality of life, and recovery. While the absence of social support appears related to greater psychiatric symptoms, poorer perceptions of overall health, and reduced potential for full community integration (Buchanan 1995; Caron et al. 1998; Corrigan & Phelan 2004; Goldberg et al. 2003; Strauss & Carpenter 1977).

To date, few studies have examined the relationship of social support with QOL in patients with psychiatric illness. However, little is known about the impact of social support on QOL in patients with OCD. Although, previous studies has demonstrated that quantity of supportive social relationships is predictive of subjective QOL in persons diagnosed with severe mental illness (Baker et al. 1992; Bengtsson-Tops & Hansson, 2001; Caron et al., 1998; Hansson et al., 2002; Lam & Rosencheck 2000; Goldberg et al., 2003; Yanos P, et al., 2001), and chronic medical illnesses (Corrigan and Phelan, 2004; Jaracz K, & Kozubski

W. 2003; Yen et al., 2004). However, the relationship between QOL and social support in patients with OCD is still unknown. Further studies are needed to examine the impact of social support and other demographic factors on QOL in patients with OCD.

2. Importance of the Study

The present study would help health professionals to broaden their concept of problem outcome to include dimensions of social support and QOL of patients with OCD. The assessment of subjective experience of patients with OCD would further help health professionals to have more in depth knowledge of patients' inner world and provide better treatment options by enhancing social support network. Patients would have the opportunity to know about their subjective world rather than being evaluated objectively by clinician alone, which is rather unreliable. Policy makers and healthcare providers would be able to articulate policy and therapeutic management measures including OCD patient's quality of life experiences.

3. Method

Participants: Fifty patients (25 males and 25 females) with obsessive compulsive disorder were recruited from the outpatient psychiatric units of different hospitals of Kashmir Valley. A psychiatrist systematically assessed all patients to confirm the diagnosis of OCD using the structured Mini-International Neuropsychiatric Interview (Sheehan, et al. 1998) based on the diagnostic schemes of the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders–Text Revision (DSM-IV-TR; American Psychiatric Association, 2000). The age of these participants ranged from 21 to 65 years.

4. Measures

World Health Organization Quality of Life Assessment – Abbreviated Version (WHOQOL-BREF). Quality of life was measured by using WHOQOL-BREF. The scale comprises of twenty six items, each one rated according to five levels of severity, covering four domains: physical health, psychological health, social relations, and environment. For each domain, scores may range from 0 to 100. In this scale high score indicates better quality of life.

Multidimensional Scale of Perceived Social Support (MSPSS). The MSPSS (Zimet, Dahlem, Zimet, & Farley, 1988) is a 12-item scale developed to assess perceived social support from three different sources, i.e., family, friends, and a significant other. Respondents are asked to rate each item on a 7-point Likert scale ranging from “1” (strongly disagree) to “7” (strongly agree). No items are reverse scored. The MSPSS produces three scores. The Cronbach's coefficient alpha values in Zimet et al. (1988) were .91, .87, and .85 for Significant Other, Family, and Friends subscales respectively. In the present sample the internal consistency reliability (Cronbach's alpha) of this measure were .85, .80 and .94 for the Significant Other, Family, and Friends subscales, respectively. The full scale Cronbach alpha value in the present study was .85.

Procedure

After seeking required permission from hospital authorities, Participants were diagnosed with OCD according to the Diagnostic and Statistical Manual of Mental Disorder – Fourth Edition – Text Revision (DSM-IV-TR; American Psychiatric Association, 2000) criteria. Participants were given information about the study and presented with the option of taking part. Written consent was received by all persons choosing to participate in the study.

After seeking consent, a suitable time and date was fixed for data collection. Before administering the questionnaire, the purpose of the study was again explained to the participants and they were assured that their responses will be kept confidential and will be used only for research and academic purpose only. A good rapport was built with the participants for getting correct responses. Some necessary instruction and guidelines were provided to them for properly filling the questionnaire. After this, the questionnaires were provided to them and they were requested to fill-up the questionnaire as per the instructions given in the questionnaire. It took an average of 20 minutes for the participants to complete the questionnaire. After completion of the questionnaire participants returned the questionnaire and they were thanked for their participation and cooperation.

Statistical Analysis of Data

The data were first exported to Microsoft Excel and then to Statistical Package for Social Sciences (SPSS) computer software used for quantitative statistical analyses. Prior to analysis, all variables were screened for possible code. To test the study research hypotheses, descriptive (mean, standard deviation, percentage etc.), and multivariate statistical method were used. Stepwise multiple regression analysis was applied to examine the role of perceived social support on quality of life of the participants. For this, separate analysis was run for each aspect of quality of life.

5. Result

Role of Perceived Social Support in Quality of Life

In order to examine whether perceived social support predicted quality of life of the participants, stepwise multiple regression analysis was applied separately for each aspect of quality of life. Result presented in Table 1 clearly indicate that while predicting physical health from all the four methods of perceived social support only family ($\beta = .34, t = 2.56, p < .01$) could enter in the equation explaining 12% variance in the physical health $R^2 = .12, F(1, 48) = 6.55, p < .01$. This indicates that participants using family social support reported significantly greater quality of life. None of the other perceived social support was found predicting variance in the physical health scores of the participants. When predicting psychological health from all four perceived social support, only family support ($\beta = .39, t = 2.95, p < .01$) was found significant predictor of psychological health which explained 13% variance in dependent measure $R^2 = .13, F(1, 48) = 2.95, p < .01$. This shows that patients using family support reported better quality of life. None of the other perceived social support was found predicting variance in the scores on psychological health of the participants.

Table 1: Result of Stepwise Multiple Regression to predict Quality of Life from Perceived Social Support

Criterion variables	Predictors	R ²	F(1, 48)	b	SE-b	β	t	95% CI
Physical Health	Family	.12	6.55**	.10	.03	.34	2.56**	.02 – .18
Psychological Health	Family	.13	8.70**	.20	.06	.39	2.95**	.06 – .33
Social Relation	Family	.27	17.66**	.27	.06	.51	4.20**	.14– .40
	Family	.38	14.42**	.23	.06	.44	3.77**	.00 – .11
	Friends			.16	.05	.34	2.90**	.00 – .05
Environment	Family	.16	9.59**	.35	.11	.40	3.09**	.12 – .58
Overall Quality of Life	Family	.23	14.50**	1.06	.28	.48	3.80**	.50 – 1.62

* $p < .05$. ** $p < .01$.

While predicting social relations from scores on various perceived social support, at step 1, family support was found as significant predictor of social relations ($\beta = .51, t = 4.20, p < .01$), which accounted for 27% variance in the scores on criterion variable $R^2 = .27, F(1, 48) = 17.66, p < .01$. At step 2, when support from friends was entered in the equation it significantly predicted change in the scores on social relations ($\beta = .34, t = 2.90, p < .01$) explaining 11% variance in dependent measure. Both these variables jointly explained 38% variance in the score on social relations which was significant $R^2 = .38, F(1, 48) = 14.42, p < .01$. Result revealed that family support and support from friends was positively related to social relations, this mean that with increasing family support and support from friends social relations increasing significantly

When predicting environmental aspect of quality of life from all four perceived social support, only family support ($\beta = .40, t = 3.09, p < .01$) was found significant predictor of environmental aspect of quality of life which explained 16% variance in dependent measure $R^2 = .16, F(1, 48) = 9.59, p < .01$. This shows that participants using family support reported good quality of life. None of the other perceived social support was found predicting variance in the scores on environmental aspect of quality of life of the participants. Finally, when predicting overall quality of life from scores on different perceived social support, it was observed that again family support significantly predicted overall quality of life ($\beta = .48, t = 3.80, p < .01$) accounting for 23% variance in the scores on dependent measure $R^2 = .23, F(1, 48) = 14.50, p < .01$. These result clearly revealed that greater use of family support improved overall quality of life of the participants.

6. Discussion

The aim of the present study was to examine the role of perceived social support on quality of life in patients with OCD, as no research has been reported in the research literature examining role of these variables. The present study is perhaps the first to reveal the role of perceived social support variables on quality of life among patients with OCD. Results of stepwise multiple regression analysis revealed perceived social support as significant predictors of scores on the measure of quality of life where family support was found positively and significantly related to different measures of quality of life. This shows that participants who used family support showed better quality of life. However,

the participants of the present study received the highest scores of perceived social support in the perceived social support from family might be due the fact that the majority of the participants included in the study were married and lived with children. Moreover, since family members of Kashmiri culture prefer living together, have strong family ties, display strong coordination and are aware of the importance of the family, this result is an expected one and is consistent with cultural properties of Kashmir. High mean scores for the perceived social support from family can be considered as a positive finding, which indicates that the patients with OCD are provided enough social support by their families. Family is the greatest source of help for the patients to deal with the effects of a chronic disease. These findings clearly supported the hypothesis that perceived social support determine the quality of life of the patients with OCD. The results presented here reinforce previous findings on the importance of social support to quality of life (Goldberg et al, 2003; Hirabayashi, et al, 2002; Mares et al, 2002; Nunes, J. 1995; Nelson, et al., 1995; Sharir, 2007; Swindells, et al., 1995). This study also showed a novel association between perceived social support and the QOL in patients with OCD. Other novel features of the study were an examination of the relationship between support from friends and QOL.

Social support from friends was also significantly and positively related to social relation aspect of quality of life and was almost a significant predictor of this aspect of QOL. These findings support those found in previous studies, which show that social support from friends was significantly correlated with quality of life (Sharir, 2007). There was a special significance for social support from friends for most of the study participants. Almost all of the OCD patients reported having some form of friendship with other psychiatric patients. Due in part to the enduring nature of their mental illness, most patients did not report having regular contact with their family members; moreover, most did not maintain regular relationships with a significant other. Of the subcomponents of social support, it would therefore be logical to conclude from these results that social support from family and friends exerted the strongest influence on quality of life in patients with OCD.

The present study suffered from a number of limitations. The study design was cross-sectional with a small sample size and participants with OCD are drawn from hospitals and hence not representative of the general population in

Kashmir. Therefore, the findings can be generalized to hospital patients with OCD rather than to general population of Kashmir. Other limitation was related to the self-assessment tools instead of face-to-face diagnostic interviews. Notably, what participants report on the self-administered questionnaire reflects its face value, which is a weak measure of validity.

Despite the above limitations, the present investigation contributes substantially and uniquely to research on social support and quality of life of patients with OCD. Findings from this study have broadened our understanding of perceives social support and its role on quality of life of patients with OCD. These findings have important implications for professionals in research, and health care practice. The present study highlights the importance of social support and how it impacts quality of life. Future research can gain more insight into potential causal relationships by studying the impact of social support over time, via a longitudinal format. Future research should seek to gain a more clear understanding of the types of interventions that might impact this population. Future research should also attempt to understand what type of support might be most beneficial to OCD patients. Perhaps a study that examined the relationship between types of social support for quality of life might provide insights into what type of interventions are most helpful. It would be interesting for future research to examine other factors that might influence perceived social support in OCD patients, such as religion, family involvement, etc. to determine if these factors impact quality of life.

7. Conflict of Interest Statement

There are no potential conflicts of interest or any financial or personal relationships with other people or organizations that could inappropriately bias conduct and findings of this study.

8. Role of funding sources

The funding sources did not play a role in the study conceptualization or design; collection, analysis, or interpretation of data; writing of the manuscript; or the decision to submit the article for publication.

9. Contributors

Dr. Mohammad Ayoob Lone and Waseem Kakroo developed the initial concept for this manuscript, conducted the literature review, and wrote the manuscript. Dr. Osama Alsaed contributed to the conceptualization of the study, offered motivation and substantive feedback for the manuscript, and assisted with editing the paper. All authors have agreed and approved the final manuscript.

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