

# Social support and bipolar disorder

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## Abstract

**Background:** Bipolar disorder is a chronic condition that affects the functioning of its carriers in many different ways, even when treated properly. Therefore, it's also important to identify the psychosocial aspects that could contribute to an improvement of this population's quality of life. **Objective:** Carry out a literature review on the role of social support in cases of bipolar disorder. **Method:** A research on the following online databases PubMed, Lilacs and SciELO was conducted by using the keywords "social support" or "social networks" and "mood disorders" or "bipolar disorder" or "affective disorder," with no defined timeline. **Results:** Only 13 studies concerning the topic of social support and BD were found in the search for related articles. Generally speaking, the results show low rates of social support for BD patients. **Discussion:** Despite the growing interest in the overall functioning of patients with bipolar disorder, studies on social support are still rare. Besides, the existing studies on the subject use different methodologies, making it difficult to establish data comparisons.

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**Keywords:** Social support, social networks, bipolar disorder, mania, bipolar depression.

## Introduction

Bipolar disorder (BD) is a chronic, recurring illness, with estimated prevalence rates of 2%, when considering the classic presentation of symptoms, and of around 2% in its subsyndromic forms<sup>1</sup>. The evolution and course of the disease can vary widely among individuals. Nevertheless, a frequently seen aspect is difficulty in readjusting properly to the social environment. This happens because of the negative impacts bipolar disorder has on the overall functioning of the person, including troubles in the workplace, low life satisfaction and difficulty in interpersonal relationships<sup>2,3</sup>.

Despite the use of adequate drug treatments, many times the course of BD is characterized by persistent symptoms and by high rates of relapse, recurrence and hospitalizations. After the acute phase, although the individual may recover substantially, reaching a state of symptomatological remission, the patient still suffers from the negative impact of the disease, presenting with cognitive dysfunction and losses in social and work spheres with subsequent loss in quality of life (QOL). The subsyndromal symptoms, especially depressive ones, may remain and thus entail a higher frequency of recurrences, with exacerbation of symptomatology and a decrease in one's general health<sup>4,5</sup>.

Within this context, the topic of QOL, considered an important indicator of the level of efficacy and efficiency of medical treatment, has been gaining relevance in research. Currently, there has been significant evidence in favor of evaluating QOL in people with BD, since the patient's follow-up should not be restricted to symptom evaluation alone, but the physician ought to, as well, aim at understanding and measuring the disorder's impact on the psychosocial parameters of the patient<sup>6</sup>.

Among the constructs that measure the psychosocial aspects, two different, albeit related, concepts are pointed out: 1- structural social support (social network) and 2- functional social support. The structural social support, which entails the quantitative aspect of social contacts, is defined as the number of people with whom the individual maintains contact or a social bond, and who might or might not offer help. The functional social support comprises the

qualitative dimension of the social network, referring to the resources made available to people in time of need, such as emotional, material and affective assistance. Furthermore, social support refers to the individual's perception as being of value within the context of the groups in which he or she participates<sup>7</sup>.

In order to understand the association between the types of social support and physical and mental health, the use of measures that assess the individual's perception and encompass the highest possible number of domains is recommended. There should also be a focus on the types of support that are related to positive results in health<sup>8</sup>.

Data in the literature regarding social support for those with mental illnesses indicate that it is possible to mitigate the negative impact of life's stress-causing events, including the symptoms brought about by the illness. The lack of help from third parties is a risk factor for symptom recurrence and results in poor prognoses for mental illness. At the same time, the set of dysfunctional symptoms, such as irritability, intolerance, and arrogance present in the acute phases of mania or hypomania, decreases one's capacity in maintaining the ability to deal with others, and, subsequently, may contribute to the reduction of social support. This bidirectional relation should be highlighted<sup>9-11</sup>.

Regarding social support and BD, assistance from family and friends seems to have positive effects in preventing a relapse, as well as on better treatment adherence and improved functionality of the individual. Although there are favorable empirical results corroborating the position that satisfactory social support provides beneficial consequences, the data concerning this topic are still inconsistent. Therefore, a sparse number of studies have been cautiously conducted, evaluating the patients in symptomatological remission. Moreover, the studies present small sample sizes and do not emphasize the development of strategies to broaden social resources for clinical practice guidelines<sup>12-14</sup>.

Traditionally, health care has been assessed and its results interpreted by means of clinical measures, such as treatment response. Thus, BD treatment, possibly up until the 1980s, when the first article on BD and social support appeared, was perceived in a reductionistic way, through clinical response measures, evaluating only the intensity of manic and depressive symptoms<sup>14</sup>.

With the advance of pharmacotherapy, those suffering from chronic illnesses, including BD, began to see the symptoms of their illnesses being managed, and consequently, they gained a longer life expectancy. However, this does not necessarily mean better QOL. Thus, research on social support emerged from the gaps where researchers recognized the need to broaden knowledge concerning multifactorial models of BD etiology, treatment and prognosis<sup>14</sup>.

The initial instruments to measure social support encompassed simple indices that covered only the presence or absence of spouse, the availability of a confidant in a crises situation, the family composition and/or involvement in social activities. These measures had limitations, since they did not inform on the quality of these relationships or specify the mechanisms through which the social network components work as a support system. In choosing the instrument evaluating social support in the research, it is important to consider the structural and functional aspects of the social relationships. Moreover, this instrument should be duly translated and validated for the studied population, before its utilization. Furthermore, the chosen scale should present a good level of reliability in monitoring social support<sup>7,8</sup>.

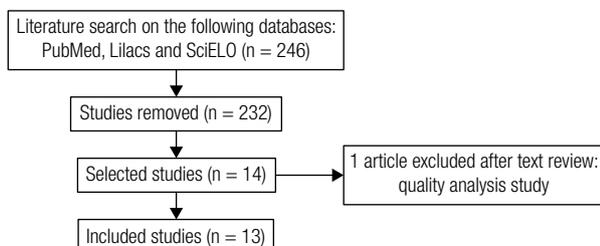
The relationship between social support, QOL, and BD, within a broader context of evaluation, is still not entirely clarified; therefore, it is crucial to conduct a better investigation of the aspects that might influence symptom exacerbation. Equally important is to know how social support functions, leading to better control of BD and a decrease in impairment in the lives of those suffering from BD, as well as their family members. So, this paper aims to review all the aspects about social support in BD patients.

## Subjects and methods

A classical review of the literature was performed, using as the database: PubMed, Lilacs and SciELO. For the selection of studies the following inclusion criteria were used: articles discussing social support and BD, such as clinical trials, reviews, case reports, conceptual papers published in English, Portuguese or Spanish, with no defined timeline. The following "Medical Subject Headings" (MeSH) were used: "social support" OR "social networks" AND "mood disorders", OR "bipolar disorder" OR "affective disorder". Bibliographical references of the attained articles were also consulted, in order to locate articles that were not identified in the primary electronic search. Exclusion criteria were: articles that are not available in full and those that do not measure social support with specific scales. Regarding the eligibility criteria, a review was made of the titles and abstracts of the retrieved studies and selected items for full-text reading. The selected studies were evaluated with respect to the inclusion criteria.

## Results

A total of 246 articles were found in the database searches and hand-searches. However, most of these studies were not specifically on the topic. So, 14 of these were deemed potentially relevant. One of them was a quality analysis study. The selected studies were evaluated with respect to the inclusion criteria and then only 13 studies concerning the topic of social support and BD were used in the search for related articles. The flowchart shows this process (Figure 1). Generally speaking, the results show low rates for social support for BD patients (Tables 1 and 2).



**Figure 1.** Flowchart detailing inclusion and exclusion selection criteria.

## Discussion

The first study that investigated social support and BD was published in 1985 and showed the relevance of psychosocial treatments in association with medication, in controlling BD. In this study, 60 BD patients were evaluated, according to the criteria of the third revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), by way of the Personal Resources Inventory (PRI), and the results showed that the use of lithium was related to high rates of social support. The researchers highlighted the importance of psychosocial variables in the course of treatment response, pointing out that social support is a part of confronting mechanisms, which positively influence the patient's prognosis<sup>15</sup>. These data were corroborated in another cross-sectional study evaluating 118 BD patients taking lithium, through the Social Support Questionnaire (SSQ), revealing that high rates of social support contributed to a decrease in mania and depression<sup>16</sup>.

Thus emerged the interest in measuring social support, seeing as the medication is not the only influence in treatment response. In 2003, research investigating the effects of social support in the remission and relapse of BD, using the Interview Schedule for Social Interaction (ISSI) and the Interpersonal Support Evaluation List (ISEL), showed that the presence of social support is important in reaching remission and that having a partner at the onset of the disease was associated with a higher chance of reaching total symptom remission, when compared to those who had no partner. Patients who were in partial remission of symptoms also reported less social support. Thus, several explanations were put forward and should be taken into consideration: insufficient social support contributes to partial recovery; more severe course of illness results in one's diminished capacity to socialize; partial remission and a low index of social support have common causes, for example, factors related to personality; and patients with partial remission of symptoms may be underestimating their support<sup>17</sup>.

Three cross-sectional studies determined that bipolar patients receive less social support, when compared to controls. One of these studies investigated the role that social support played in BD patients, age 50 or older, through the Duke Social Support Index (DSSI). The study subjects were community residents and recruited at psychiatric units: 29 who had BD were older than 50: 56 who had BD were young adults (between 18 and 49) and 23 were healthy controls. Of these, 20 were in mania, 24 were in the depression phase and 49 were euthymic, although there was not the criterion or the instrument to evaluate euthymia. The results showed that: compared to the control group, the older BD patients had a diminished perception of social support in spite of the difference in the number of social interactions, size of social network or quantity of instrumental social support they received. Furthermore, compared to healthy controls, the young adult BD patients also had an inadequate perception regarding social support and there was a reduced number of social interactions, although they did not present differences in the size of the social network and instrumental support they received. The group of older BD patients, compared to the group of young adults, had a similar and inadequate perception regarding social support. Ultimately, no differences were reported in the social support scales between the older group with BD, based on the age at diagnosis<sup>18</sup>.

In 2004, Wilkins related BD, work and social support, and determined that one in four employed people with BD type I stated never, or almost never, having received social support in their lives. Moreover, he proved that social support is fundamental in helping reduce the negative impacts that BD symptoms may cause in seeking and keeping a job. Despite the great need for assistance, BD type I patients have a low level of social support. The possibility of never getting married, separate or getting divorced is relatively higher in those with BD than in people without this disorder. Most likely, this reflects the disorder's effects on more intimate relationships. Despite the large sample size, this study has relevant limitations, such as the use of in-person diagnostic interviews and over the telephone (86%), the non-stratification of people with BD type I, II and the types related to substance use or general medical conditions, which hinders the comparison with other studies<sup>19</sup>.

**Table 1.** Social support in bipolar disorder patients (1985 to 2000)

Authors	Study design	Sample	Instruments	Results
O'Connell <i>et al.</i> , 1985	Cohort (1 year)	60 BD type I patients, without confirmation of euthymia	RDC PRI	Low social support influences recurrence of manic and depressive episodes Greater social support is associated with good treatment outcome with lithium
Romans and McPherson, 1992	Cross-sectional	52 euthymic BD patients; 47 random community sample	RDC ISSI	BD patients have impoverished social relationships, when compared to a random community sample Manic episodes seem to have more detrimental effect on social relationships than depressive episodes do
Staner, 1997	Cohort (2 years)	27 recovered BD patients; 24 recovered unipolar patients and 26 healthy controls	RDC. HDS e BMS SSNI	Social support is unable to predict new episodes in this sample. It is not a major factor in the recovery of the individual
Kulhara <i>et al.</i> , 1999	Cross-sectional	118 BD type I and II patients, without confirmation of euthymia	ICD SSQ	Low social support influences recurrence of manic and depressive episodes Social support significantly correlates to response to lithium. The more social support, the better response to lithium
Johnson <i>et al.</i> , 1999	Cohort (6 months)	59 BD type I patients, without confirmation of euthymia	SCID ISEL ISSI	Individuals with high social support recover more quickly from mood episodes and are less vulnerable to increases in depression over time
Johnson <i>et al.</i> , 2000	Cohort (9 months)	31 BD type I patients	SCID ISEL	Social support components and self-esteem were not linked with follow-up mania symptoms, but they have a protective effect against depression

Research Diagnostic Criteria (RDC); Personal Resources Inventory (PRI); Interview Schedule for Social Interaction (ISSI); Hamilton Depression Scale (HDS); Bech-Rafaelsen Mania Scale (BMS); Social Support Network Inventory (SSNI); International Classification of Diseases (ICD); Social Support Questionnaire (SSQ); Interpersonal Support Evaluation List (ISEL); Structured Clinical Interview for DSM-IV (SCID).

**Table 2.** Social support in bipolar disorder patients (2003 to 2013)

Authors	Study design	Sample	Instruments	Results
Johnson <i>et al.</i> , 2003	Cohort (1 year)	94 BD patients, without confirmation of euthymia	ISEL ISSI	Social support is lower in patients with BD in partial recovery than those in full recovery Patients with relapses have lower levels of social support compared with patients who did not relapse
Beyer <i>et al.</i> , 2003	Cross-sectional	29 older BD patients, 56 younger BD patients, without confirmation of euthymia, 23 healthy controls	SCID MMSE DSSI	Both older and younger BD patients perceived their social support as inadequate compared with controls of similar age
Wilkins, 2004	Cross-sectional	BD type I patients	CIDI MOSSS	BD type I patients have low social support
Cohen <i>et al.</i> , 2004	Cohort (1 year)	52 BD type I patients, without confirmation of euthymia	SCID SSI	Higher levels of stress and perceptions of less available and poorer quality close relationships are associated with recurrence
Strauss and Johnson, 2006	Cohort (6 months)	58 BD type I patients	SCID HDS BMS ISEL	Stronger treatment alliances were associated with higher levels of patient social support
Weinstock and Miller, 2010	Cohort (1 year)	92 BD type I patients during an acute episode	HDS BMS ISEL	Social support emerged as a unique predictor of depression at the 1-year follow-up Low levels of social support may place individuals with BD at risk for subsequent depressive symptoms
Eidelman <i>et al.</i> , 2012	Cross-sectional	35 euthymic BD type I patients and 38 healthy controls	SCID IDS-C YMRS ISEL	BD patients have more deficient social support compared to controls

Interpersonal Support Evaluation List (ISEL); Interview Schedule for Social Interaction (ISSI); Structured Clinical Interview for DSM-IV (SCID); Mini-Mental Status Examination (MMSE); Duke Social Support Index (DSSI); Hamilton Depression Scale (HDS); Bech-Rafaelsen Mania Scale (BMS); Scale of Supportive Interactions (SSI); Composite International Diagnostic Interview (CIDI); Medical Outcome Social Support Scale (MOSSS); Clinician Rated Inventory of Depressive Symptomatology (IDS-C); Young Mania Rating Scale (YMRS).

A more recent cross-sectional study compared 35 people with BD in symptomatological remission and 38 healthy controls, relating social support and social tension with parameters of sleep and social rhythm. The Clinician Rated Inventory Depressive Symptomatology (IDS-C), the ISEL and the Young Mania Rating Scale (YMRS) were administered on the first visit and then 28 days later, in order to assess depressive and hypomania symptoms. The results showed that social support was lacking in those with BD, when compared to the control group. Furthermore, this research confirmed that social support represents a clinically relevant psychosocial factor, which

fosters a significant impact on the lives of those with BD, even those evaluated in a state of euthymia<sup>13</sup>.

The studies on social support and BD also showed positive responses to social support during a depressive episode. Four studies confirmed that social support has an influence on the recurrence of the depressive episode. One of the studies investigated the effect of social support on symptom severity and episode recurrence of the disorder. They prospectively evaluated 59 people with BD type I, in symptomatological remission or not, by means of the ISEL, the ISSI and the Bedford College Life Events and Difficulties Schedule (LEDS),

determining that the individuals with high social support recovered more rapidly from mood episodes and were less vulnerable to the recurrence of depressive episodes. These results highlight that the positive and negative aspects of social relationships are important determinants of mood symptoms<sup>20</sup>.

Another prospective study by this group evaluated the presence of manic and depressive symptoms in 31 people with BD type I, through the ISEL and the Rosenberg Self-Esteem Scale (RSE), which measures self-esteem. It was shown that these psychosocial factors only have influence on the course of bipolar depression and not on mania. Thus, these studies suggested that social support is a significant factor in diminishing the severity of depressive episodes over time<sup>18</sup>. In fact, a study evaluating 52 people with BD, with a follow-up of one year, which analyzed the effects of stressors and of social support in the course of the illness, showed that high levels of stress as well as lower availability and quality of the patient's interpersonal relationships predict depressive relapse, even when under a physician's care. However, the follow-up period of only one year and the small sample size were limitations of this study, which hindered the detection and analysis of this interference on manic episodes<sup>21</sup>.

Remaining on this line of study, Weinstock and Miller monitored 92 BD type I patients during one year, with the aim of evaluating the relation between family functioning, social support (by way of the ISEL scale) and functional impairment during the course of BD. For this, they recruited patients during acute mood episodes, where they took part in clinical screening with pharmacological and family interventions, or with pharmacological ones alone. In this study, social support emerged as the only predictor of depressive symptomatology, without, however, having any influence on mania. This result is consistent with previous studies that showed that a low index of social support fosters a subsequent risk of depressive symptoms in people with BD. However, further investigation is necessary to see whether some component of the support might also positively affect the course of manic episodes<sup>11</sup>.

Thus, social support has become a relevant variable in the control of BD, for not only was it observed that the presence of said support exerts a protective effect, but also that BD may impair the social support of patients with BD. A study evaluating social network and social support, through the Interview Schedule for Social Interaction (ISSI) scale, showed that being married and having a good job broaden social interactions, increasing the possibility of good social support. In this study, patients with predominantly manic symptoms obtained a lower score on social interaction than those with depressive symptoms. This result reflects the negative social repercussion that mania causes, since during a manic episode the individual may challenge, humiliate and assault friends or family members, causing them to keep their distance. Moreover, it was observed that the older the person was and the longer time of the illness duration, the lower the index of social support. In this study, care was taken to clinically evaluate whether the patients were in [euthymia?], however, no euthymia rating scale was administered<sup>22</sup>.

In this review, only one study showed the positive effect of social support in mania. Strauss and Johnson investigated (through the ISEL) the influence of social support, among other variables, on 58 people with BD, for the therapeutic alliance. In fact, the findings of this study showed that strong alliances are associated with greater social support. Thus, one can relate these results with other studies that raise the importance of social support in BD. Furthermore, these researchers concluded that strong alliances predict a lower frequency of negative attitudes regarding medication, less stigma relating to BD, as well as the possibility of helping to reduce symptoms over time<sup>23</sup>.

Generally speaking, among the articles selected for this review, only one showed that social support is not an important factor in the individual's recovery. In this article, self-esteem, social adjustment, social support and attributional style were compared with healthy controls, bipolar and unipolar patients in prophylaxis with lithium or antidepressant, and there was no interference of the presence of social support in the drug response. Nevertheless, a substantial

limitation was the small sample size. Thus, one might question the representativeness of the sample and the strength of this study<sup>24</sup>.

Despite growing interest in the overall performance of someone with BD, aiming at full recovery, the studies on social support are still scarce and unsubstantial. Most of them suggest that patients with greater social support present fewer recurrences and relapses of depressive episodes, particularly. However, there is still little evidence regarding social support and mania prevention. Thus, it is important to investigate whether there is a social support domain that intervenes in the course of manic episodes.

Thus, assessments of psychosocial parameters, as well as the impact of interventions in this area, are necessary in order to integrate the current perspective of the interactions of social, psychological and biological factors within the course and prognosis of BD. Interventions focusing on interpersonal relationships, such as family therapy and interpersonal psychotherapy, might be especially important to consider within this context<sup>2</sup>.

This review has limitations. It is not a systematic review and meta-analysis, since the topic SS in bipolar disorder has few studies and these present different methodologies that hinder data comparison. However, there are strengths: it is a very careful review puts forward important points about this issue, since SS has been gaining attention in the attempt prevent relapse and to promote good outcome of the BD treatment. Therefore, it can be useful to generate future studies.

## Conclusions

Research related to social support and BD are inconsistent and have very diverse methodologies; at times, with small sample sizes, where patients are evaluated in the acute phase and with different subtypes of BD (types I and II). Along this line, studies conducted on symptomatic patients are biased, seeing as one's perception is normally distorted during times of depression and mania. Nonetheless, despite these difficulties, it can be pointed out that social support has a protective function in the course of BD, granting benefits to the patient. Thus, it is extremely relevant to conduct studies on euthymic patients, in order to investigate the different domains of social support and their correlations with BD episodes.

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