SOCIAL SUPPORT, SOCIAL DYSFUNCTION AND STRESSFUL LIFE EVENTS IN NEUROTIC PATIENTS.
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ABSTRACT

The relationship between social support, stressful life events and psychosocial dysfunction was studied in 197 neurotic patients comprising 65 patients of Generalized Anxiety Disorder, 81 of Dysthymia and 51 of Dissociative (conversion) Disorders. It was seen that Dysthymics perceived themselves to have significantly less social support in comparison to Generalized Anxiety or Dissociative Disorders patients. Significant correlations between social support and life events and social support and dysfunction were also obtained and it was observed that lack of social support is negatively correlated with greater life stresses and dysfunction.

Key Words: Social support, social dysfunction, life events, neurosis

INTRODUCTION

Over the past two decades, a growing body of knowledge based on theory and research suggest profitable effects of social support on a wide variety of outcomes including physical health, psychological well-being and social functioning. Empirical evidence indicates that social support not only promotes health but also shields the individual from physical or mental breakdown, maladjustment and deleterious effect of psychosocial stressors (Cassel, 1976; Cobb, 1976; Berkman & Syme, 1979; House, 1981; Gottlieb, 1981, 1983; Cohen & Syme, 1985; Cohen & Wills, 1985; Ganster & Victor, 1988).

Though there is no universally agreed definition of social support, it usually denotes the existence or availability of people on whom one can rely and people who let us know that they care about, value and love us (Sarason et al. 1983). Social support system has also been conceptualised as an enduring pattern of social ties that play a major role in maintaining psychological and physical integrity of the individual. Bowlby (1969, 1973, 1977, 1980) has contended that social support bolsters the capacity to withstand and overcome frustration. In the context of our country social support primarily comes from the family mainly from the parents or the spouse. The social support provided by the family has the components of emotional as well as physical support. Social network and other social bonds also are rich sources of social support but these are more functional rather structural aspect of social support.

Social support has been linked to psychiatric morbidity, depression and suicide (Broadhead et al. 1983). Research data extant shows that most people need a minimum level of social interaction with others, failure to do so increases the risk of emergence of neurotic disorder (Henderson, 1974; Bowlby, 1977; Henderson et al. 1978a,b.) Henderson et al. (1980) whilst supporting the association between psychiatric morbidity and depleted social relationship point out that perceived lack of social support available through social bonds is related to increased psychological morbidity. Parker & Barnett (1987) have also suggested that if perceived lack of social support is a risk factor for the development of neurotic disorders, then inception and maintenance of such disorders might be decreased if during the time of adversity availability of adequate social support is ensured.

A number of cross-sectional studies have demonstrated association between a variety of social support measures, and depression, anxiety and other psychological morbidity (Miller & Ingham, 1976; Lin et al. 1979; Barrera, 1981; Billings & Moss, 1981; George et al. 1989). This finding is further reinforced by investigators who found that psychologically distressed persons has less rewarding social network and social ties (Holahan & Moss, 1981; Gottlieb, 1983; Cohen & Wills 1985)

Stressful life event is an other important variable that appears related to the genesis or relapse of psychiatric disorders (Birely & Brown, 1970). Social
support facilitated coping with life crises and adaptation to change, and is thought to protect the individual from the harmful consequences of stressful life events (Nuckolls et al. 1972; Gore, 1973; Larocco et al. 1980; Sarason, 1981; Abdel-Halim, 1982; Williams et al. 1981; Blazer, 1982). More recently, Dalgard et al. (1995) explored the relationship between life stressors, social support and mental health and found that the buffering effect of social support applied only to those who had external locus of control and those with internal locus of control do not seem to have same degree of need for social support to cope with life stressors.

Thus, the interface between social support and stressful life events, and psychological infirmity seems complex. However, very few studies have concurrently explored the relationship between these variables and neurotic illness. Moreover, no worthwhile literature about the relationship between social support and psychiatric morbidity from India is available. Given the notion that India is regarded as a society with strong traditional family ties, cohesive joint family system and rather restricted social mobility, we felt that to study the relationship between social support and life events, and neurotic illnesses may enhance understanding about this subject. Therefore, the present work was undertaken with the following objectives:

1. To assess social support, social dysfunction and occurrence of stressful life events in neurotic patients
2. To study the relationship between social support, life events and social dysfunction in neurotic patients.

**MATERIAL AND METHODS**

The study was conducted in the out-patient clinic of the Department of Psychiatry of the Postgraduate Institute of Medical Education and Research, Chandigarh from where consecutive patients fulfilling the study criteria were recruited in the study. The Psychiatric out-patients unit of the Institute is a general all purpose psychiatric clinic which is attended by patients of both sexes and of all age groups i.e. from children to geriatric populations.

**Inclusion criteria and diagnostic groups:**

The patients were interviewed by one of us (PK - a psychiatrist with considerable experience) and diagnosis of a neurotic illness was established according to the criteria of ICD-10 of the World Health Organization (1992). The diagnostic groups included in the study were Generalized Anxiety Disorder (ICD-10 code F41.1), Dysthymia (ICD-10 code 34.1) and Dissociative (conversion) disorders (ICD-10 codes F44.4-F44.7)

**Instruments of Assessments:**

The following instruments were employed to assess social support, stressful life events and social dysfunction:

1. **Social Support Questionnaire (Pollack & Harris, 1983 as modified for use in India by Nehra & Kulhara, 1987):**
   - The Social Support Questionnaire of Pollack & Harris (1983) was translated in Hindi, the local language. Back-translation was done to check adequacy of translation as well as semantic closeness to the original questionnaire. After this the questionnaire was item analysed and subjected to test-retest reliability. The original questionnaire had 23 items but the modified Hindi version of the Questionnaire has 18 items. Each item of the scale has 4 options which range from 'no agreement' (scored as 1) to extreme agreement which is scored as 4. Higher score indicated that more social support is available to the individual.

2. **Presumptive Stressful Life Events Scale (Singh et al. 1984):**
   - This scale was developed locally and standardised on Northwest Indian population. It has certain items of cultural relevance to the Indian people. The scale has 52 items and is administered in a semi-structured interview manner.

3. **Dysfunction Analysis Questionnaire (Pershad et al. 1985):**
   - This scale was developed in the Department of Psychiatry of the Institute and was standardised on
local population. The Dysfunction Analysis Questionnaire (DAQ) assesses dysfunction in relation to the illness in five areas: vocational, social, family, personal, and cognition.

**ASSESSMENT OF THE PATIENTS:**

One of us (PK) established the diagnosis as per inclusion criteria and recorded clinical information, and one of us (RC-a research psychologist) recorded socio-demographic details of the patients and administered the psychological tests as mentioned above. All assessments were done once only.

**Statistical Analyses:**

The data generated were analysed by Analysis of Variance (ANOVA), Pearson's Product Moment Co-efficient of Correlation and Students t test.

**RESULTS**

The total number of patients studied was 197 of which 65 were of Generalized Anxiety Disorder (GAD), 81 of Dysthymia and 51 of Dissociative (conversion) Disorders. The socio-demographic and clinical characteristics of the patients in various study groups are shown in Table 1. There were significant differences among the 3 diagnostic groups with regard to the variable of age and patients in Dissociative (conversion) Disorders group were significantly younger than patients of either Dysthymia or GAD. Also there were significantly more females in the Dissociative Disorders group than in Dysthymia or GAD groups.

The mean duration of illness among the 3 study groups also showed significant variability (F = 2.533; df 2,194; P<0.01). Duration of illness in Dissociative Disorders group was significantly less than Dysthymia (t = 2.032; df 130; P<0.05). There were significantly more patients with an illness of less than 2 years in GAD and Dissociative Disorders groups compared to Dysthymia group ($X^2 = 9.47$; df2; P<0.01). (Table 1)

**APPENDIX**

### TABLE 1

| Variable | GAD | Dysthymia | Dissociative |
|----------|-----|-----------|--------------|
| **Disorder** | | | |
| Age in years | mean (SD) | 31.67(8.14) | 34.09(7.60) | 28.17(7.94) |
| Duration of illness in Yrs | mean (SD) | 3.66 (3.97) | 4.51(4.01) | 3.05(2.97) |
| >2 years | | 41 | 31 | 22 |
| Gender* | | | |
| male | 43 | 39 | 11 |
| female | 22 | 42 | 40 |
| Marital status | | | |
| never married | 13 | 17 | 12 |
| ever married | 52 | 64 | 39 |
| Formal education in years: | | | |
| up to years | | 25 | 34 | 29 |
| >than 10 years | | 39 | 47 | 22 |
| Occupation | | | |
| employed | 43 | 45 | 13 |
| unemployed | 3 | 4 | 1 |
| housewife | 14 | 25 | 31 |
| student | 5 | 7 | 6 |
| Religion | | | |
| Hindu | 48 | 57 | 30 |
| Sikh | 17 | 21 | 19 |
| other | 3 | 3 | 2 |
| Type of family: | | | |
| nuclear | 30 | 40 | 28 |
| joint extended | 35 | 35 | 23 |
| Place of residence: | | | |
| urban | 41 | 55 | 25 |
| rural | 24 | 25 | 28 |

$F$ Ratio = 8.459; df 2,194; P<<0.0005.

Comparison between dysthymia and GAD not significant.

Comparison between dysthymia and Dissociative Disorders: t 4.187; df 130; P<0.0001.
comparison between GAD and Dissociative Disorder:
\[ t = 2.241; \text{df} 114; \ P < 0.025. \]
\[ \text{ANOVA: } F = 2.533; \text{ df } 2; \ P < 0.01. \]
comparison between dysthymia and dissociative disorders:
\[ t = 2.23; \text{df} 130; \ P < 0.005. \]
\[ \chi^2 = 9.47; \text{df} 2; \ P < 0.01. \]
\[ \chi^2 = 22.64; \text{df} 2; \ P < 0.0005. \]

Perceived social support available to the patients in various diagnostic groups is shown in Table 2. Dysthymsics perceived themselves to be lacking in social support and had significantly less scored on social support compared to the patients of GAD or Dissociation. There was no significant difference between GAD and Dissociation (conversion) patients on the variable of social support. On considering availability of social support according to place of residence of the patients, it was observed that rural subjects perceived themselves to have significantly more social support (mean 46.25, SD 9.70) compared to urban subjects (mean 43.47, SD 8.02) (\( t = 2.30; \text{df} 195; \ P < 0.05 \)).

**TABLE 2**

| Social support in various study groups |
|---------------------------------------|
| Dysthymia | GAD | Dissociative Disorders |
| mean      | 42.01 | 47.10 | 45.27 |
| SD        | 7.66  | 9.22  | 8.63  |

ANOVA: \( F = 7.72; \text{DF} = 2, 194; \ P < 0.01. \)

Comparison between Dysthymia and GAD:
\[ t = 3.66, \ P < 0.01. \]

Comparison between Dysthymia and Dissociative Disorders: \( t = 2.27, \ P < 0.01. \)

The occurrence of life events in the three study groups and the weighted mean stress scores of these are shown in Table 3. Dysthymics had experienced significantly greater number of life events compared to GAD and also had significantly higher weighted stress score.

**Table 3**

| Stressful life events in the study groups |
|------------------------------------------|
| Dysthymia | GAD | Dissociative Disorders |
| Name of the events | mean | 9.82 | 8.52 | 8.88 |
|               | SD  | 2.90 | 2.80 | 3.30 |

**Weighted stress scores**

| Mean | 397.75 | 338.07 | 366.64 |
| SD   | 134.51 | 127.61 | 155.17 |

1. ANOVA: \( F = 3.39; \text{df} 2, 194; \ P < 0.01. \); comparison between dysthymia GAD- \( t = 2.88, \ P < 0.01. \).

2. comparison between dysthymia GAD- \( t = 2.76, \ P < 0.01. \)

As mentioned earlier, the DAQ (Pershad et al., 1985) assesses dysfunction in five areas and the scores obtained by the 3 study groups are shown in Table 4. It should be noted that higher scores denote more dysfunction in that area. There were significant differences among all study groups in all of the areas. Dysthymics had significantly more social, personal and family dysfunction. Dissociative group had more vocational and cognitive dysfunction.

**Table 4**

| Dysthymia Analysis Questionnaire- DAQ scores in the study groups |
|---------------------------------------------------------------|
| Dysthymia | GAD | Dissociative Disorders |
| Social dysfunction: | mean | 80.59 | 73.90 | 75.37 |
|               | SD  | 13.43 | 16.18 | 14.80 |
| Vocational dysfunction: | mean | 76.64 | 70.58 | 75.29 |
|               | SD  | 17.43 | 15.98 | 16.44 |
| Personal dysfunction: | mean | 76.54 | 70.58 | 75.29 |
|               | SD  | 11.32 | 12.10 | 11.82 |
| Family dysfunction: | mean | 71.48 | 59.90 | 67.76 |
|               | SD  | 15.44 | 14.74 | 15.79 |
| Cognitive dysfunction: | mean | 65.23 | 60.21 | 66.62 |
|               | SD  | 12.44 | 12.40 | 12.87 |

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The relationship between social support and social dysfunction, and social support and the stress experienced due to life events was explored by linear correlations analyses (Table 5). Significant negative correlations between perceived social support and these variables were obtained.

**Table 5**

| Groups             | Social support mean (SD) | Dysfunction mean (SD) | Statistics    |
|--------------------|--------------------------|-----------------------|---------------|
| Dysthymia          | 42.01 (7.36)             | 80.59 (13.43)         | r = 0.65, P < 0.01 |
| GAD                | 47.19 (9.22)             | 73.90 (16.18)         | r = 0.66, P < 0.01 |
| Dissociative Disorder | 45.27 (8.63)           | 75.37 (14.34)         | r = 0.65, P < 0.01 |

**DISCUSSION**

We undertook this investigation with a view to assess social support, stressful life events and dysfunction in a group of anxiety, depression and dissociative patients. We also studied the relationship between these variables. The three study groups differed significantly on some of the clinical variables e.g. age of the patients, gender of the patients and the duration of the illness and it was observed that dysthymics had been ill for longer duration and that there were more females in the dissociative group. Also, dissociative patients were younger in age. However, no particular meaning can be attached to these observations as these differences are reflection of the function of the diagnosis and are in line with trend seen for the psychiatric clinic of the Institute as a whole.

Dysthymics rated themselves to be lacking in available social support and in comparison to GAD and dissociative groups had significantly less perceived social support. In this study we have used a scale which is a subjective measure of social support. It has been suggested by various workers especially Henderson (1984) and George et al. (1989) that subjective measures of social support are suspect because they may be influenced by the prevailing affective state of the patients. It is quite likely that because of depressed affect, dysthymics have a negative view of themselves and the world around them and as such may rate themselves to be lacking in social support and network of supportive ties when this may not be correct in reality. The cross sectional design of our study is a limitation because of which the contaminating effect of affect can not be ruled out. However, our observation that depressives lack in perceived social support is in conformity with other investigations reported in the literature.

In our study, we found that regardless of diagnostic categorisation, rural subjects perceived themselves to have significantly more available social support compared with urban subjects. Majority of the population in India lives in the rural sector where social mobility is less and cohesive family ties in the form of joint family system still prevails unlike urban India where nuclear families are the norm of the day and familial ties have somewhat fragmented. Therefore, the rural urban difference in perceived social support is not surprising, on the other hand this only underscores the role of family factors in generating meaningful social bonds and feelings of togetherness which so very richly contribute in ones perception of availability of social support.

Dysthymics had experienced significantly more life stresses compared to GAD group. In relation to depression, this observation is in agreement with the observations of other workers. The pattern of dysfunction in the three study groups varied significantly but generally reflects the psychopathology of these groups.

The most salient finding of the study is the demonstration of a negative correlation between social support and stress and dysfunction. It is well recognised that psychological morbidity impairs the coping and socio-occupational capabilities of an individual. The negative correlations between social support and stress and dysfunction suggest that lack of supportive relationships makes an individual even more vulnerable. However, due to cross-sectional nature of the study and lack of control over other intervening variables we are unable to categorically state the exact role played by social support in the genesis of neurotic disorders, the vulnerability of individual to withstand stress of psychosocial dysfunctioning.
In comparison to other works in this area, our study has certain advantages. All patients recruited in this study had clinically diagnosed illness according to a well established system of classification. The study has not only assessed social support but also other psychological variables which lead to such disorders (e.g. life events) or give rise to the consequences (e.g. dysfunction). In addition the relationship among these variables has also been sought. The limitations of the work are cross-sectional design, single assessment of patients and no assessment of other variables that help in the formation of social support (e.g. personality variables). From the perspective of clinical practice and research, better understanding of the role of social support either in buffering or protecting the individual from deleterious effects of life stressors and dysfunction is essential. From the present work social support appears to emerge as an important factor in these but more still needs to be done.

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