ORIGINAL ARTICLE

Quality of life and Social Support among Diagnose Bipolar Patients

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ABSTRACT

Aim: To ascertain the relationship between quality of life and social support in bipolar patients who have been diagnosed. **STUDY DESIGN:** cross-sectional research design

Place and duration of the study: The research was performed impatiently on the Sheikh Zayed Medical College, Rahim Yar Khan at the Department of Psychiatry and Behavioral Sciences, which ran from January 2018 to July of 2019.

Method: Data was retrieved from 100 patients, with diagnosed patients of bipolar affective disorder. Quality of life and social support were assessed by quality of life scale (QOLS) developed by Burckhardt and Berline social support scale (BSSS) developed by Berline.

Results: Research claims a close relationship between the presence of such things as quality of life and social help for people with Bipolar Disorder.

Conclusion: Bipolar is linked to inadequate health and quality of life and social isolation, mostly due to ineffective social skills. Social support is critical to emotional stability and quality of life. It may help patients deal with difficulties and reduce depression and help in both the recovery phase and positive results of psychiatric treatment. What is currently being sought to be learned is how social care has an impact on the level of well-being for bipolar patients.

Keywords: Quality of life, bipolar, validation, generalization

INTRODUCTION

There are a multitude of negative impacts when someone is mentally unstable, both on the individual himself and his loved ones. Patients who are mentally ill may experience a loss of help from family friends, coworkers, or partners, resulting in a small or reduced social support network composed mostly of family members or professionals in mental health services¹. Evidence of current population studies have shown that small social networks can trigger both mania and bipolar disorder with increased hospitalizations due to agitation and poor quality of life(QOL), and it's also increased the probability of future cognitive re-hospitalization². Individuals who are physically ill have physical and emotional impairments. Due to this condition, an individual's inability to participate in social activities may hamper their ability to fully realize their full potential³

Bipolar affective disorder (BPAD) is one of the most prevalent mental disorders, and is ranked sixth leading global cause of disease, with lifetime incidence of about 3 in the overall population.⁴ This state of disorder is characterized by repeated episodes during which the patient's mood and degree of behavior change dramatically. The bipolar category of active mania has often involves elevated mood and behavior (mania or

hypomania), and may, in some cases, be accompanied by depressive symptomatology and reduced motivation and decreased activity (depression)⁵.

Bipolar I Disorder—characterized by at least seven-day-long manic episodes or by serious manic side effects including hyper side effects that necessitate healing facility treatment. Frequently, cheerless acts occur as well, for an average duration of around fourteen days. Scenes of sorrow with mixed highlights (exhibiting both dejection and hyperactivity) are often possible⁶. Bipolar II Disorder is marked by depressed and hypomanic episodes, but not by outright hyper episodes as previously described. Individuals with bipolar symptoms who experience several unusual shifts in mood, as well as adjustments in activity and sleep, might engage in peculiar or bizarre behavior. Mood scenes are diametrically opposed to the everyday dispositions and habits of the person. Outrageous changes in the vitality, action, and rest impediment have dynamic properties which force adjustments in a character's disposition⁷.

Bipolar confusion is severe and can result in risky behavior, including self-destructive tendencies; nevertheless, it is treatable with medication and solution. The high and low periods of bipolar issue are regularly so outrageous that they meddle with regular daily existence⁸. Bipolar confusion is completely common, and one of a hundred adults will undoubtedly develop the syndrome at some point in their lives. Bipolar confusion may occur at any age, despite the fact that it most often occurs between

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the ages of 15 and 19, and sometimes occurs after the age of 40. People from all fundamentals are similarly prone to create bipolar commotion. The illustration of expressive periods in bipolar confusion changes generally among personages. For example, certain individuals have just three or two bipolar scenes throughout their lifespan and remain stable in the center, whilst others have several sections⁹.

Bipolar turmoil is a genuine psychological maladjustment in which basic feelings turn out to be strongly and frequently erratically amplified¹⁰. As per Encyclopedia Britanica (n.d.) Quality of life, how much an individual is solid, agreeable, and ready to take part in or appreciate life occasions.¹¹ The term personal satisfaction is characteristically questionable, as it can allude both to the experience an individual has of his or her own life and to the living conditions in which people get themselves. Somebody's personal satisfaction is the degree to which their life is agreeable or fulfilling¹².

New research assesses the personal satisfaction of patients experiencing bipolar turmoil (BD) in examination with the all-inclusive community. Researchers found patients with BD present more regrettable psychological well-being than the overall public; moreover, they found bipolar patients have a poorer personal satisfaction at a physical level. Bipolar confusion (BD) is an endless, repeating ailment, with assessed predominance rates of 2%, while thinking about the exemplary introduction of side effects, and of around 2% in its sub-syndromic shapes. The development and course of the illness can change broadly among people. By and by, an every now and again observed viewpoint is trouble in straightening out appropriately to the social condition.¹³ This occurs as a result of the antagonistic impact bipolar disorder has on the individual's overall functioning, which includes workplace difficulties, scoundrel fulfillment, and relationship difficulties. Inside this specific situation, the subject of QOL, thought about an essential pointer of the level of viability and effectiveness of restorative handling, has existed picking up significance in research. Presently, there has stood huge proof for assessing QOL in individuals with BD.¹⁴

The word "social help" appears in several conversations, though, regularly. Social assistance entails providing companions and other people, including relatives, to lean on during times of need or emergency to provide you with a broader focus and a more optimistic emotional self-view. Social assistance increases emotional happiness and acts as a buffer to unfavorable life events. Social help can take diverse structures: Social help as verbal and nonverbal correspondence among beneficiaries and suppliers that lessens vulnerability about the circumstance, oneself, the other, or the relationship, and capacities to upgrade a view of individual control as far as one can tell.¹⁵

The objective of the study were to analyze relationship linking social funding to a worth of life in BD, impact of community livelihood and value of life in BD

patients and to examine the contribution of quality of life enhances the treatment effectiveness.

METHODOLOGY

Sample of this study consists of 100 BD diagnosed patients from Sheikh Zayed Hospital, Rahim Yar Khan. It is taken by purposive sampling technique. This study correlation research method is used.

Quality of life: This edition of the Quality of life scale (QOLS) contains sixteen objects, as opposed to the fifteen in the initial Flanagan version. Item 16 "independence doing for yourself" was omitted after a retrospective analysis demonstrating the instrument's gratifying validity of populations of prolonged disease.

Social Support: The Berlin social support scales (BSSS), given by Ralf Schwarzer and Ute Schulz 2000. Used in this, scoring is on a 4 point liker type scale. Somewhat disagree (1), fairly disagree (2), quite agree (3), and strongly agree (4) are all appropriate endorsements. Scale ratings are calculated in two ways: by adding up the responses to items or by producing the scale imply score.

Procedure: A consent form was developed to inform the subjects about the nature of the study. Reference letter was shown to the concern authorities of Sheikh Zayed hospital and permission to start research work was taken. Only diagnosed patients with bipolar affected disorder selected. Participants were selected through purposive sampling technique. Three questionnaires were sent to the clinical population and they were told to complete the demographic sheet first, and then the Quality Of Life Scale and Berlin Social Support Scales were utilized to assess the quality of life of identified people with bipolar affective disorder. Every respondent was rated on the basis of instruction are provided. SPSS was used to analyze the results t test and regression used.

RESULTS

Descriptive statistics were computed for demographic variables, age, gender, qualification, marital status and family system. t- Test was used to make comparison between QOL and Social Support in male and female BD patients. Correlation analysis was used to check correlation between QOL and Social Support in BD patients.

Results in table 1 shows that on quality of life gender has a significant difference with socialization and independence. While on other aspects of QOL gender does not have any significant difference.

In table 2 results show that on social support, gender has significant difference with item 4 (there is always someone for me when I need comforting) of emotional base subscale and with item 5 (whenever I need help, I ask for it) of support seeking subscale

Table 1: Independent sample t-test between gender and quality of life among BD patients.

Variable	Gender			
	Male		Female	
	M SD		M SD	
			t p df	
Material comforts	3.20	1.78	3.26	1.79 .17
health	3.47	1.48	3.00	1.63
			1.53	.12 98

Relation with parents	3.39 1.48	3.80 1.59	1.33 .18 98
Having & tending children	2.91 1.48	3.28 1.51	1.23 .21 98
Near Relation with spouse	3.14 1.59	2.90 1.65	.74 .46 98
Close friends	4.08 4.06	3.44 1.57	1.05 .29 98
Aiding others	3.47 1.36	3.28 1.27	.72 2.47 98
Participating in public matters	3.52 1.47	3.46 1.61	.19 .84 98
Learning school and knowledge	3.10 1.57	2.94 1.48	.52 .59 98
Understanding yourself	3.33 1.65	2.94 1.64	1.18 .24 98
Work-job	2.95 1.52	2.84 1.63	.35 .72 98
Expressing yourself creatively	3.22 1.38	3.28 1.31	.21 .82 98
Socializing	3.20 1.21	3.76 1.27	2.24 .02* 98
Reading, listening music	3.58 1.30	4.09 1.58	1.75 .08 98
Participating in recreation	3.43 1.33	3.80 1.42	1.33 .18 98
Independence	3.50 1.45	2.94 1.25	2.05 .04* 98

Table 2: Independent sample t-test between gender and social support among BD patients.

Variable Gender							
Male Female							
M SD M SD t p df							
SSSES1	2.83	.81	2.78	1.03	.240	.811	98
SSSES2	2.83	.72	2.76	.78	.424	.672	98
SSSES3	2.58	.79	2.90	1.01	-1.74	.083	98
SSSES4	3.06	.83	2.69	.87	2.15	.03*	98
SSSIS1	2.50	1.01	2.55	.87	.306	.76	98
SSSIS2	2.72	.91	3.5	3.85	-1.34	.18	98
SSSIS3	2.75	.88	2.57	.91	.959	.34	98
SSSIS4	2.62	1.10	2.40	1.07	1.02	.31	98
SSSNS1	2.56	1.07	3.30	4.33	-1.15	.25	98
SSSNS2	2.75	.86	2.46	1.05	1.48	.14	98
SSSNS3	2.43	.92	2.63	.92	1.06	.29	98
SSSNS4	2.54	1.09	2.44	.99	.476	.635	98
SSSSS1	2.62	.86	2.48	1.07	.735	.464	98
SSSSS2	2.60	.86	2.61	1.05	-.058	.954	98
SSSSS3	2.93	1.03	2.86	.84	.383	.703	98
SSSSS4	2.70	.98	2.76	.98	.309	.758	98
SSSSS5	2.77	.97	2.19	.97	2.97	.004**	98

Table 3.: Correlation of QOL with sum of social support's subscales

Variables	SSS1	SSS2	SSS3	SSS4
Material comforts	1.00	.03*	.09	.03*
Health	.16	.05*	-.14	-.21
Relation with parents	.22	.16	.15	.26
Having or rearing children	.22	.01	.16	-.15
Close relation with spouse	.24	-.15	-.15	.08
Close friends	.14	.06	.05*	.02*
Helping others	.26	-.14	.13	.03*
Participating in organizations	.25	.01**	.08	-.04
Learning-knowledge	.15	.07	-.07	.03
Understanding yourself	.20	.19	.08	.05*
Work-job or in home	.18	.24	.04*	.02*
Expressing yourself	.10	.03*	.09	.04*
Socializing	.18	.11	.05*	-.04
Reading, listening music	.12	.22	.02*	-.12
Participating in active recreation	.12	.31	.20	.23
Independence	.05*	.09	-.24	.18

*p < .05, **p < .01, ***p < .001

It is illustrated in table 3 that QOL item 16 (independence) has significant correlation with emotional support subscale of social support, while item 1 (material comforts), item 2 (health), item 8 (participating in organizations) and item 12 (expressing yourself) have significant correlation with perceived instrumental support subscale of social support. Similarly, item 6 (close friends), item 11 (work-job), item 13 (socialization) and item 14 (reading, listening music) have significant correlation with

need for support subscale of social support. While item 1 (material comforts), item 7, 11, 12 and 13 have a significant correlation with support seeking subscale of social support

DISCUSSIONS

The present examination was led to think about connection between quality of life and social help among bipolar disorder (BD) patients. In BD individuals experience the ill

effects of inclination changes, discouragement and hyper state of mind side effects. In sorrow the patients feel much pushed and low levels of state of mind. While in hyper term the patient feel much elated and energized. These emotional episodes influence their standard life, their social, word related, instructive and every single other part of life. It is generally trusted that personal satisfaction of BD patients isn't at expected level WHO¹⁶. Bipolar is linked to inadequate health and quality of life and social isolation, mostly due to ineffective social skills.¹⁷ Social support is critical to emotional stability and quality of life. It may help patients deal with difficulties and reduce depression and help in both the recovery phase and positive results of psychiatric treatment. What is currently being sought to be learned is how social care has an impact on the level of well-being for bipolar patients¹⁸.

The present examination was led to think about connection between personal satisfaction and social help among bipolar confusion (BPAD) patients¹⁹. It is widely believed that personal satisfaction among BPAD patients is lower than predicted. Quality of Life is described as an individual's perception of their position in life in relation to the way of life and value systems in which they reside, as well as in relation to their goals, preferences, models, and concerns²⁰.

Essentially lower social help was found in patients in incomplete recuperation contrasted and those in full recuperation ($p=0.003$). Patients who backslid amid a 1-year imminent follow-up period saw an altogether lower level of social help than patients with no backslide ($p=0.012$). Bipolar patients with full inter-episode reduction see more social help than the individuals who don't accomplish full abatement. Poor social help may expand the danger of backslide in bipolar confusion²¹.

The current examination tentatively inspected the effect of social help on manifestation seriousness and recuperation from scenes in bipolar confusion, both as an immediate impact and as a support of life occasions. Fifty-nine people with Bipolar I issue were pursued longitudinally with month to month indication seriousness interviews. Social help was estimated by the Interpersonal Support Evaluation List and the Interview Schedule for Social Collaboration, and life occasions were evaluated utilizing the Life Events and Difficulties Timetable.

CONCLUSION

Bipolar disorder is associated to inadequate health and quality of life and social isolation, mostly due to ineffective social skills. Social support in patients with bipolar disorder is positively associated with Quality of life. Quality of life OF Bipolar patients can be maintain with social support. It may help patients deal with difficulties and reduce depression and help in both the recovery phase and positive results of psychiatric treatment.

Implications: This study has a number of implications:

1. To begin, the research identifies a variety of individuals who may need social help following exposure to BPAD.
2. However, the findings show that people may be motivated to participate in social support activities for their loved ones who suffer from BD.

3. Health care professionals may learn from the data provided by this study and may use it to advise their immediate care.

Recommendations:

1. Large sample size might improve result findings and evidential support.
2. In-depth study or comprehensive analysis is expected to determine social support and quality of life in BD patients.
2. Using other research techniques might improve description and prediction of the target behavior.

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