Social Support and Quality of Life for Patients with Depressive Disorders

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Abstract
Background: Depression is recognized as one of the major health threats in the 21st century. It is a maladaptive psychosocial phenomenon that can affect many areas of patients' lives and have a negative impact on their quality of life (QoL) and social support. Aim of the study: to assess social support and quality of life for patients with depressive disorders. Research design: A descriptive correlational research design was used to achieve the aim of the present study. Sample: A total convenient sample of 100 adult male and female depressed patients was included in the study sample. Setting: This study was carried out at outpatient clinic of Minia Hospital for psychiatric health and addiction. Patients who diagnosed as having organic brain diseases, mentally handicapped, substance abused were excluded from the study. Tools of data collection: The required data was collected through three tools. Socio – demographic Data Sheet, Interpersonal Support Evaluation List (ISEL) and Quality of Life Scale. Results: showed that 66% of depressed patient had low social support, while 50% of the depressed patients had low QOL level and there were statistical significance differences between education levels with QOL. Also, there were positive associations between QoL and social support & all its subscales except self esteem support. Conclusion: The current study showed that the highest percentage of the depressed patients had low social support and QOL. Recommendations: Establishing educational centers and hot lines for family awareness about the importance of social support and quality of life for depressed patients.
Key Words: depressive disorder, social support, quality of life

Introduction

Depression is the oldest and most frequently described psychiatric illness. The existence of depression has been documented since biblical times. Normal feelings of sadness are appropriate in many situations. It would be abnormal not to feel sad in certain situations, such as when a loved one dies or when other losses occur in a person's life. However, these feelings are usually short –lived and do not persist in altering the person's ability to function. When an individual's mood causes clinically significant distress or impairment in social or occupational functioning, a diagnosis of depressive disorder is warranted [(1)].

It is impossible to convey adequately the personal pain and suffering experienced by an individual going through a severe depressive episode so, the manifestation of depressive phenomena is a complex, dynamic, biopsychosocial process involving lifespan and cultural aspects. All races, all ages, and both genders are susceptible to depressive episode, although some individuals are more vulnerable than others [(2)]. Because there is a notable connection between depressive disorder and suicide, early diagnosis and intervention may increase the chances of a favorable outcome [(3)].

Social support is defined as information leading the subject to believe that he is cared for, loved, esteemed, valued and belongs to a network of communication and mutual obligation [(4)]. During the last 30 years, researchers have shown great interest in the phenomena of social support, particularly in the context of health. Prior work has found that those with high quality or quantity of social networks have a decreased risk of mortality in comparison to those who have low quantity or quality of social relationships[(5)]. Moreover, social isolation itself was identified as an independent major risk factor for all-cause mortality. Social support influences on morbidity, mortality, and quality of life in chronic disease populations, understanding the mechanisms responsible for such associations, and how we might apply such findings to design relevant interventions [(6)].

Social support is a vital and effective part of depression recovery; it can turn around damaging isolation, affect a person's life focus, and generate solutions for depression management. The same author added that learning more about how this powerful social force can positively effect someone living with depression, when you are depressed, isolation turns you away from life, this creates a self-fulfilling cycle where you feel increasingly rejected and remain disconnected, increasing the chances that your connections might fade or weaken. This dangerous combination affects how you see your very existence. Instead of turning your vision toward growth and living, you become focused on avoiding the most pain. And unfortunately, death can easily become the leading candidate for pain relief [(7)].

The world health organization (WHO) defines QoL as ''an individual's perception of his/ her position in life in the context of the culture and value systems in which he/she lives and in relation to his/her goals, expectations, standards and concerns. Several authors have proposed models of QOL for people with mental illnesses. Patients with less severe depressive symptoms were found to have higher levels of functioning and satisfaction in daily activities, role functioning and social relationships [(8)].

Indicators of QOL include life satisfaction, self-esteem, general health, functional status, socioeconomic conditions, satisfaction of needs, one's experience of life, and self-rated health status [(9)]. People with depression suffer from persistent psychosocial and occupational impairments and diminished quality of life after recovering from acute episodes [(10)]. So, Quality-of-life (QOL) assessment and improvement have recently been recognized as important components of health care, in general, and mental health care, in particular[(11)].

Significance of the Study

If projections prove accurate, then by 2020, depression will become the second cause of the global disease burden. Already depression affects around 121 million people (WHO 2011) with almost half of population of western world experiencing at least an episode of depression during their life-time [12].

According to health statistics in Minia Hospital for psychiatric health and addiction as a study area includes 19 patients admitted by recurrent depressive disorders and 94 patients admitted by bipolar mood disorder (2013). As well as, 15 patients are admitted by recurrent depressive disorders and 52 patients admitted by bipolar mood disorder (2014), with taking into account that the actual number of patients in this period missed and not documented due to new hospital reforms.

Depressive disorders constitute a large proportion in the global burden of disease, both in the developed and developing countries and increase the risk for suicide. Hence, the present study is under taken to assess social support and quality of life as perceived by patients with depressive disorders. As well as providing guidance and recommendations that should be reflected in psychiatric nursing education and practice.

Aim of the study

The aim of the current study was to assess social support and quality for patients with depressive disorders.

Research Questions:

- Is there a relation between social support and depression?
- Is there a relation between quality of life and depression?
- Is there a relation among social support and quality of life and depression?

Subjects and Methods

Research Design:

A descriptive correlational research design was used to assess social support and quality of life for patients with depressive disorders.

Setting:

This study was conducted in Minia Hospital for psychiatric health and addiction which founded in 1997, the capacity for the hospital was 53 beds. The hospital serves Minia governorate.

Subjects:

A convenience sample consisted of 100 depressed patients.

Inclusion Criteria:

Patients who were attending the psychiatric outpatient clinic of Minia Hospital for psychiatric health and addiction were selected according to the following criteria:

1. Patients of both sex were included.
2. Patient's age ranged from 20-55 years.
3. Patients diagnosed for all types of depression by the psychiatrist who was responsible for the treatment using DSM IV as a diagnostic criterion.

Exclusion Criteria:

1. Patients who diagnosed organic brain disease or mental retardation.
2. Patients with substance abused.

Tools of data collection:

Appendix 1:Socio – demographic Data Sheet:

It was developed by the researcher and included: personal data such as patient age, gender, level of education, occupation, marital status, diagnosis and number of previous hospitalization.

Appendix 2: Interpersonal Support Evaluation List (ISEL):

Interpersonal Support Evaluation List (ISEL) developed by Cohen 1983, it contains 40 items and designed to assess perceptions of social support. A 40 items scale made up of four subscales. The subscales are: 1) Tangible Support,2) Belonging support, 3) Self-esteem support and 4) Appraisal support(13).

Appendix 3: Quality of Life Scale:

The original scale was constructed by Lehman (1986) to assess QOL of psychiatric patients. It consists of (57) items divided into six domains or subscales.

The first subscale, comprising 12 items covering the physical health, the second subscale consisted of 8 items reflecting self-care, the third subscale included 14 items, representing patient's emotional status, the fourth one consisted of 13 items related to personal and social relationships, the fifth subscale included 5 items which assess the patient's ability to making decision, to work to carry out the work duties, and the patient's ability to taking responsibilities and the last subscale consisted of 5 items used to collect data about spiritual concerns and personal beliefs[14].

Validity and Reliability

The tools were reviewed by three panels of experts in psychiatry and psychiatric nursing to test the content validity of the tools. Reliability of ISEL and QoL tool performed to confirms its consistency by test and retest were 0.954& .933 respectively.

Pilot Study

The pilot study was conducted on 10 patients (10%) who met the inclusion criteria was done to investigate and ensure the feasibility, objectivity, applicability, clarity and adequacy of the study tools and to determine possible problems in the methodological approach or tool. The results of the pilot study used to test the proposed statistical and data analysis methods. The tools were completed without difficulty, adding support to the validity of the instrument. The time required for completion of the interview questionnaire didn't exceed than 30 minutes. The pilot study was excluded from the main study sample. Pilot testing helped the investigator plan for data collection.

Ethical Consideration

A written initial approval was obtained from the ethics committee of the scientific research at Faculty of Nursing, Minia University. Written Informed consent was obtained from each participating patients after explaining the nature and benefits of the study. Each assessment sheet was coded and patient's names were not appearing on the sheets for the purpose of anonymity and confidentiality.

Data Collection Procedure

An official permission obtained from the director of Minia Hospital for psychiatric health and addiction. Patients who met the selection criteria were selected to participate in the study. Patients with depressive disorders were interviewed on individual basis to explain the nature and purpose of the study. Structured interviews were conducted in one room of the out-patient clinic; questions were asked and recorded by the investigator. Measures were taken to protect Patient's ethical rights.

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The researcher went to the outpatient unit 2 days per week (Tuesday, and Wednesday from 9 pm to 1 pm). The researcher had interviews with all patients with depressive disorders and collect data from them; this interview taken about 30 minutes with every patient. Data collection was conducted over a twelve months' period extending from November 2015 till December 2016.

Statistical analysis of data

The collected data were coded, categorized, tabulated, and analyzed using the Statistical Package for the Social Science (SPSS 20.0). Descriptive data were expressed as mean and standard deviation. Qualitative data were expressed as frequency and percentage. Data were presented using descriptive statistics in the form of percentages, frequency mean and standard deviation. Inferential statistical tests of significance such as Friedman's ANOVA, Pearson correlation, and independent t-test were used to identify group differences and the relations among the study variables. Level of significance at $p < 0.05$ was used as the cut of value for statistical significance.

Results

Table 1: Socio-demographic data of depressed patients (n= 100).

Personal data	No.	%
Age / years		
20 – 29	30	30.0
30 – 39	40	40.0
40- 49	26	26.0
50- 59	4	4.0
Mean ± SD	34.8 ± 8.3 years	
Educational level		
Illiterate	17	17.0
Read and write	9	9.0
Primary school	6	6.0
Secondary school	14	14.0
Diploma degree	33	33.0
University	21	21.0
Marital status		
Single	40	40.0
Married	41	41.0
Divorce	17	17.0
Widow	2	2.0

Table (1): describes the socio-demographic data of the depressed patients namely age, level of education and marital status. Age range of the sample was 20 – 59 years old. Table (1) indicates that 40% of the depressed patient was 30 – 39 years with mean age 34.8±8.3. Concerning patients' level of education, the same table indicates that, there were 33% of the depressed patients had diploma level of education. As regards marital status table (1) indicates that, 41% of depressed patients were married.

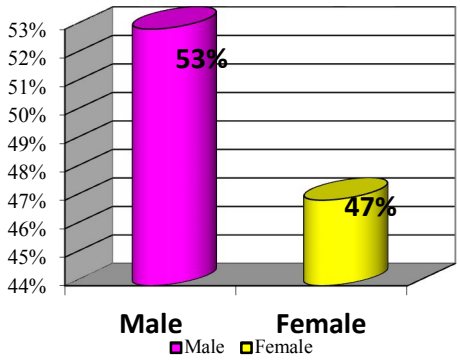

Fig. 1 Gender of depressed patients

Fig. 1 shows that, there were more than half (53%) of the depressed patients were males, while 47% of depressed patients were females

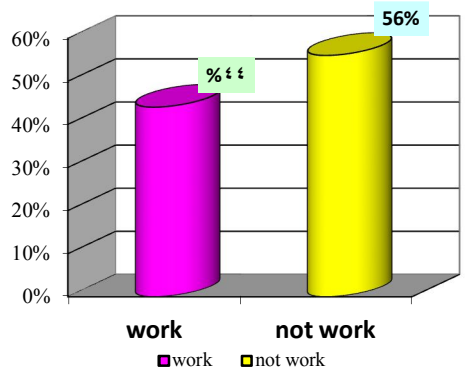

Fig. 2 Occupation of depressed patient

Fig. 2 shows that more than half of the studied sample who included in the study were unemployed (56%).

Table 2: Distribution of depressed patients according social support domains (n= 100)

Social Support	Definitly true		Probably true		Probably false		Definitly false	
	No.	%	No.	%	No.	%	No.	%
Appraisal Support								
- There is someone I could turn to for advice about making career plans or changing my job.	23	23.0	16	16.0	6	6.0	55	55.0
- If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.	53	53.0	5	5.0	7	7.0	35	35.0
Tangible Support								
- If I needed an emergency loan of 100 pounds, there is someone (friend, relative, or acquaintance) I could get it from.	13	13.0	3	3.0	3	3.0	81	81.0
- It would be difficult to find someone who would lend me their car for a few hours.	93	93.0	2	2.0	5	5.0	0	0.0
Self-esteem Support								
- I am more satisfied with my life than most people are with theirs.	3	3.0	1	1.0	27	27.0	69	69.0
- I am closer to my friends than most other people are to theirs.	7	7.0	3	3.0	17	17.0	73	73.0
Belonging Support								
- If I wanted to go on a trip for a day, I would have a hard time finding someone to go with me.	77	77.0	5	5.0	3	3.0	15	15.0
- No one I know would throw a birthday party for me.	87	87.0	4	4.0	9	9.0	0	.0

Table 2 presents the four domains of social support, as regard to appraisal support, 55% of the studied sample felt that there was no someone could turn to for advice about making career plans or changing their job. with respect to tangible support, the majority of the studied sample (93%) said that it was difficult to find someone would lend them their car for a few hour. concerning the self esteem support, 73% of the studied sample mentioned that they were not closer to their friends. in relation to the belonging support, 87% of the studied sample did not know someone would throw a birthday party for them.

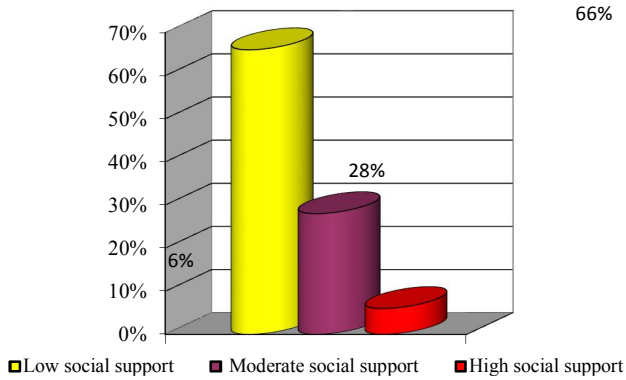

Fig 3 presents that 66% of depressed patient had low social support compared with 6% of them had high social support.

Table 3: distribution of depressed patients according quality of life domains (n= 100).

Quality of life	Never		Sometimes		Always	
	No.	%	No.	%	No.	%
(Physical Health)						
- I can do any heavy work.	85	85.0	6	6.0	9	9.0
- Participate in the activities of daily living and recreational activities (walking - clean – listen to Radio - watch TV- reading)	69	69.0	16	16.0	15	15.0
(Personal Care)						
- I have the ability to choose my clothes with an elegant way.	56	56.0	22	22.0	22	22.0
- I eat very less than usual.	16	16.0	26	26.0	58	58.0
(Emotional state)						
- I am talking badly about myself.	12	12.0	16	16.0	72	72.0
- I find I am able to express my feelings spontaneously.	72	72.0	21	21.0	7	7.0
(Social and personal relationships)						
- I have the difficulty of planning for my future.	12	12.0	8	8.0	80	80.0
- I can work a strong and continuing friendships.	92	92.0	3	3.0	5	5.0
(The degree of self-reliance)						
- I feel that a great responsibility to work on.	5	5.0	12	12.0	83	83.0
- I have the difficulty in making my decisions.	6	6.0	15	15.0	79	79.0
(Religious habits and personal beliefs)						
- I have faith that the work of the forces of human worship	29	29.0	11	11.0	60	60.0
- I sense that God is capable of everything and is capable of my healing.	30	30.0	10	10.0	60	60.0

Table 3 presents the quality of life domains, as regard to physical health, the majority of the studied sample (85%) never can do any heavy work. in relation to personal care, 58% of them mentioned that they always eat very less than usual. Concerning emotional state subscale, 72% of them always talking badly about themselves and feel that they can never able to express their feelings spontaneously. Regarding the social and personal relationships which the majority of the studied sample (92%) can never work a strong and continuing friendship. With respect to the self reliance subscale, 83% of the studied sample always feel that a great responsibility to work on.

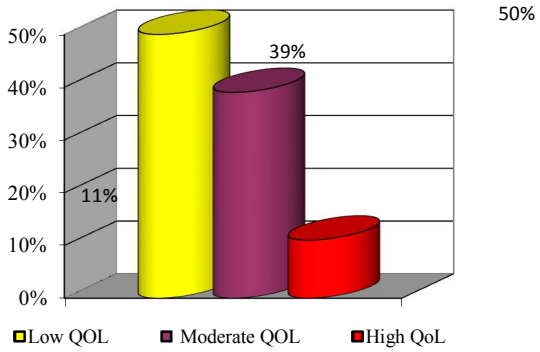

Fig. 4: Distribution of depressed patients according to levels of QOL (n=100)

Figure 4: represents that, 50% of depressed patients had low QOL level followed by 39% of them had moderate QOL level and only 11% had high QOL level.

Table 4: Differences between age group according to social support domains among depressed patients (n= 100)

Social support domains	Age				f	P -value
	20-	30-	40-	50- 59		
Appraisal	12.9 ± 10.7	11.8 ± 10.4	13.5 ± 10.7	18.5 ± 5.8	5.662	.02*
Tangible	12.9 ± 8.8	12.2 ± 8.7	13.9 ± 9.1	21.3 ±7.3	1.036	.315
Self esteem	9.2 ± 6.8	9.7 ± 5.9	10.6 ± 6.4	6.8 ± 5.9	.323	.573
Belonging	10.7 ± 6.7	10.1 ±6.5	10.7 ± 5.9	14.3 ± 7.7	.227	.636
Total social support	45.7 ± 29.8	43.7 ± 28.5	48.8 ± 29.3	60.7 ± 16.4	2.484	.122

*Statistical significantly differences (P value < 0.05)

Table4: shows that, patients aged between 50- 59 years had higher total social support scores than other patient's ages as regard social support domains except self- esteem scores and there were no statistical significance differences between social support and its domains with age except appraisal domain in which P - value ≤ 0.02.

Table 5: Differences between age group according to quality of life domains among depressed patients (n=100)

QOL domains	Age				f	P -value
	20-	30-	40-	50- 59		
Physical Health	20.5 ± 6.8	20.4 ± 6.5	18.8 ± 5.6	22.3 ± 5.7	.597	.619
Personal Care	14.9 ± 4.6	15.2 ± 4.4	15.0 ± 3.7	19.3 ± 3.6	1.277	.287
Emotional state	21.9 ± 7.9	22.3 ± 7.5	20.9 ± 6.5	24.3 ± 6.8	.320	.811
Social and personal relationships	19.9 ± 5.4	21.0 ± 5.4	20.2 ± 6.1	21.2 ± 6.4	.317	.813
The degree of self-reliance	6.9 ± 2.0	6.9 ± 2.3	6.7 ± 1.7	7.1 ± 2.1	.092	.964
Religious habits and personal beliefs	10.8 ± 3.5	10.2 ± 3.5	10.0 ± 3.6	13.8 ± 1.1	1.524	.213
Total QOL	94.8 ± 24.2	96.1 ± 24.4	91.6 ± 20.6	107.0 ± 21.6	.567	.638

Table 5 presents that, patients aged between 50- 59 years had higher total QOL scores than other patient's ages but with no statistical significance differences were found in which p- value ≥ 0.05.

Table 6: Differences between types of occupation according to social support domains among depressed patients. (n=100)

Social support domains	Occupation		t	P -value
	Work	Not work		
Appraisal	12.3 ± 10.0	13.2 ± 10.7	.426	.671
Tangible	12.9 ± 8.8	13.5 ± 8.9	.376	.708
Self esteem	9.5 ± 6.2	9.8 ± 6.4	.206	.837
Belonging	9.8 ± 5.7	11.6 ± 6.9	1.019	.311
Total Social support	44.5 ± 26.4	47.7 ± 30.4	.545	.587

Table 6 shows that, mean scores of total social support and its domains were higher among not working patients than working patients and there were no statistical significance differences between social support and its domains with occupation in which P - value > 0.05.

Table 7: Differences between types of occupation according to quality of life domains among depressed patients (n=100)

QOL domains	Occupation		t	P -value
	Work	Not work		
Physical Health	20.2 ± 6.3	19.9 ± 20.2	.193	.847
Personal Care	15.6 ± 4.4	14.9 ± 4.2	.787	.433
Emotional state	22.3 ± 7.6	21.6 ± 7.1	.433	.659
Social and personal relationships	20.6 ± 5.9	19.6 ± 6.0	.150	.881
The degree of self-reliance	7.0 ± 2.1	6.7 ± 1.9	.892	.374
Religious habits and personal beliefs	10.5 ± 3.8	10.4 ± 3.3	.217	.829
Total QOL	95.8 ± 24.2	93.4 ± 22.5	303	.763

Table 7 illustrates that, mean scores of total QoL and its domains were higher among working patients than not working patients with no statistical significance differences were found in which P - value > 0.05.

Table 8: Correlation between social support and quality of life among studied group. (n=100)

		Physical health	Personal care	Emotional state	Social & personal relationships	Self – reliance	Religious	Total QOL	Appraisal	Tangible	Self esteem	Belonging
Physical Health	r											
	P											
Personal Care	r	.528										
	P	.000**										
Emotional state	r	.832	.460									
	P	.000**	.000**									
Social and personal relationships	r	.786	.354	.774								
	P	.000**	.000**	.000**								
The degree of self-reliance	r	.573	.386	.666	.615							
	P	.000**	.000**	.000**	.000**							
Religious habits and	r	.267	.372	.142	.228	.051						
	P	.007**	.000**	.157	.023*	.614						

personal beliefs												
TOTAL QOL	r	.267	.372	.142	.868	.689	.399					
	P	.007**	.000**	.157	.000**	.000**	.000**					
Appraisal	r	.288	.096	.252	.252	.048	.258	.275				
	P	.004**	.344	.011*	.012*	.636	.010**	.006**				
Tangible	R	.264	.154	.243	.249	.034	.134	.252	.829			
	P	.008**	.125	.026*	.013	.733	.184	.012*	.000**			
Self-esteem	R	.141	.037	.246	.170	.065	.088	.134	.584	.595		
	P	.160	.711	.036*	.091	.523	.381	.185	.000**	.000**		
Belonging	R	.276	.122	.258	.262	.024	.114	.265	.824	.801	.691	
	P	.005**	.225	.010**	.009**	.815	.260	.008**	.000**	.000**	.000**	
Social support	R	.279	.102	.264	.264	.008	.141	.266	.932	.921	.771	.923
	P	.005**	.314	.008**	.008**	.933	.162	.007**	.000**	.000**	.000**	.000**

** Correlation IS significant at the 0.01 level (2-tmled). *Correlation is significant at the 0.05 level (2-tailed).

Table 8 finds that there were statistically positive correlation between physical health with appraisal, tangible, belonging and totally social support (r = .288, P = .004, r = .264, P= .008, .r =.276, P = .005, and r = .279, P = .005 respectively). As regard, emotional state there were positive associations between it and social support & all its subscales (r = .252, P = .011, r= .243, P= .026, r =.246, P = .036, r .258, P = .010, and r =.264, P = .008 respectively). While in social & personal relationships there were positive associations between it and appraisal, belonging, totally social support (r = .252, P = .012, r = .262, P = .009, and r =.264, P = .008 respectively). Also, there were positive associations between QoL and social support & all its subscales except self esteem support (r = .275, P = .006, r = .252, P = .012, r =.265, P = .008, and r .266, P = .007 respectively).

As regard to QOL, there were statistically positive correlation between physical health with emotional state and social & personal relationships (r = .832, P = .000, and r = .786, P = .000 respectively), between emotional state and social & personal relationships (r = .774, P = .000) also, between totally QoL and social & personal relationships (r = .868, P = .000).

As regard to social support there were positive correlations between appraisal domain and tangible, belonging, and totally social support (r = .824, P = .000, r = .932, P = .000), tangible domain and belonging, and totally social support (r = .801, P = .000, r = .921, P = .000), also, between totally social support and self -esteem and belonging domain (r = .771, P = .000, r = .923, P = .000 respectively)

Also, there were positive correlation between Self – reliance with social support and all subscale except self -esteem, and Religious with social support and all subscales (r= .287, p= .004, r = .293, p = .003, r = .252, p = .027, r = -.261, p= .0009 respectively)

Discussion

Depressive disorders are highly prevalent in the general population worldwide [(15)]. Several studies have demonstrated the impact of depression on quality of life (QOL), with depressed patients displaying QOL impairments which are equal to or greater than those of patients with other chronic conditions [(16)]. Social support is seen as one of the social determinants for overall health in the general population. Impaired social support and feelings of loneliness are considered to be risk factors for depression [(17)].

Based on the results of the present study, more than half of the studied sample who included in this study were males (Fig 1). This can be attributed to many factors. Among of them was unemployment which affects more on males as they were the dominant persons on the family, Other factors include inability to meet the responsibilities of work, caring for family, or other important activities. However, few studies support the current study. The results were in the same line with Sawant et al. [18] who mentioned that; around more than half of studied patients were males.

The previous finding was disagreed with Ana & Marcelo [(16)] who mentioned that; mostly of the sample (73%) were female. Also, Aprajita et al [(19)] stated that more than half of sample were female. similarly, a study held by Rayan [(20)] to assess the level of QOL among Jordanian patients with major depressive disorder, and to examine the possible relationship between QOL and other factors (demographic variables). He found that 63.4 % were women and 36.6% were men.

As regard to age, the present study showed that, more than one third of the studied sample the ages were ranged between 30 – 39 years with mean age was 34.8 ± 8.3 years (Table 1). This can be attributed to different problems as loss of parent or significant person, the death of a close family member could be devastating and feelings of depression were among the most common reactions. Other problems included unemployment, marital stress and divorce problems. The results were congruent with Van et al. [(21)] who reported that the mean age was 38 years. According to Aprajita et al., [(19)] who mentioned that mean age of the sample was 33.84 years. Also, these findings are supported by Lima [(22)] who reported that the mean age was 38 years. Similarly, Rayan, [(20)] in his descriptive correlational design on 161 patients diagnosed by MDD. The study results revealed that the mean age was 36.2 years.

With respect to the educational level, the current study revealed that more than one third of the studied sample had diploma level (Table 1). This finding was explained by presence of high rate of unemployment in my study. Also, thinking too much about failures, having too much desire for something and then realizing that he cannot achieve them, and any such activities which hurt him from the core can lead him to depression if he doesn't divert his mind from it. The previous findings were in the same line with Berlim & Fleck, [(23)] who reported having mean education of 9 years (a diploma program of education). The results were in agreement with Aprajita et al., [(19)] who reported that; majority of the sample were educated.

As regard to marital status, the current study showed that, more than one third of the studied sample was married. This can be attributed to marital stress make people vulnerable to depression (Table1). Every marriage faces challenges; the most common causes of stress in marriage were disagreements and miscommunication between couples and behaviors that can become destructive over time. This finding demonstrated the association between depression and marital relationship. This finding was supported by Rayan [(20)] who found that more than one third of depressed patient were married. Similarly,

Sawant et al., [18] mentioned that the majority of depressed patient were married. According to Aprajita et al., [19] who mentioned that half of the patient were unmarried. Although, Akay [24] mentioned that the majority of depressed patients were married. The results didn't agree with Tawil, Sediki , and Hassan, [25] who stated that; the majority of the samples were 83% married.

With respect to the depressed patient's occupation, the current study revealed that, more than half of the studied sample was not working (Fig 2). Reasons of unemployment might be unavailable job, secondary education or inability to work .Unemployment associated with many feelings as sadness, hopelessness and financial anxiety or loss of income, loss of social ties, loss of self esteem and stigma. The unemployed tend to have higher levels of impaired mental health including depression. So, the current study had shown that higher levels of depression and unemployment are correlated. The same finding was reported by Tawil, Sediki , and Hassan, [25] who mentioned that the majority of depressed patient were not working. This finding was interpreted by the association between work or occupation and depression and the negative effect of unemployment on depressed patients. These results are supported by Tai [26] which reported that 82.2% of depressed patients were unemployed.

Regarding levels of social support, the present study revealed that more than two third of the studied patients had low social support (Fig 3). This explained by the relationship between social support and depression and the current study suggested that social support moderates impact on depression. This finding was supported by Wang et al. [31] which mentioned that there was impairment in social support in depressed patient and he also showed that social support was negatively correlated with depression. This result was in consistent with fagundes et al., [32] which illustrated that social support plays a significant regulating effect on depression.

With respect to distribution of social support domains, the current study showed that, the majority of the studied sample had low level of tangible support, they said that it was difficult to find someone lend them an emergency loan (Table 2). These findings could be referred to lack of tangible support which the studied sample was missing any physical assistance provided by others, as in some situations, individuals need material goods or actions to help them in challenging situations. Also, the studied sample suffered from absence of persons taking on responsibilities for them or taking an active stance to help them manage a problem they were experiencing. According to Bowen [28], absence of tangible support making stressful situations more damaging to mental health and increasing depressive symptoms. The results were congruent with Grav, [29] who reported that; lack of tangible support was significant predictors of depressive symptoms.

In relation to belonging support, the current study reported that the majority of the studied group had low level of belonging support which may be related to fact that social relationships and social support are potent variables that can reduce feelings of depression and defend health against the impact of stress (Table 2). Also, impairment in belonging support was associated with fewer friendship contacts, fewer family contacts and impairment in quality of life. As well, lower belonging support is an important reason for decreases in life satisfaction and increases in depressive symptoms [30].

As regard to QOL subscales, there were impairment in physical health which the majority of the studied sample never could do any heavy work (Table 3). This result could be attributed to painful physical symptoms as headache and back pain and presence of depressive symptoms that did not give the patient the initiation for doing anything. These findings were in the same line with Jain et al., [33] who mentioned that all levels of depression were associated with decreased work productivity. Also, these results were supported by Kessler et al., [34] on his study which presented that 64.3% have fully or intermitted impaired work functioning and agreed with Novick et al., [35] who illustrated that 52% of depressed patients had pain symptoms that affecting work performance and worsening QOL. These results were also broadly consistent with the results of Wilson [36] who indicated that there was a negative relationship between activity participation and recreation and depression.

With respect to social and personal relationships, it was found that the majority of studied sample could not work a strong and continuing friendship (Table 3). Reasons varied and the studied sample showed their aloneness in different ways, some of them expressed feelings of rejection, uselessness, and feeling of insecurity in social situations and lack of meaningful relationships, others reported that they were preoccupied with their thoughts that engaged them from having continuing friendship. This finding was supported by Sawant [18] who presented that 65.7% had impairment in personal relationships.

The current study showed that; half of the studied sample had low QOL level followed by more than one third of them had moderate QOL (Figure 4). These findings were in consistent with Ruo et al [37] who mentioned that 67% of depressed patients had diminished QOL. These results were consistent with the results of Trompenaars et al.,[38] who stated that the severity of depression was significant in negatively influencing QoL of patients has been confirmed, lower levels of QoL among patients with major depression. The same finding was reported by Gupta, [39] which mentioned that depressed patients have significantly impairment in QOL and vice versa.

In relation to age, the current study showed that there was no statistical significant relationship between social support and its domains with age except appraisal support (Table4). This result could be interpreted by the importance of availability of someone to talk to about patient's problems in this age. Also, the appraisal support had a direct and buffering effect on the stressors associated with the studied sample. In contrast, Sharir, [40] reported that, total social support and its subcomponents were all positively correlated with patient age.

The current study presented that no statistical significance differences between QOL and age were found (Table 5). This finding was consistent with Saraçlı [41] who mentioned on his study that there was not a correlation between age and QOL.

In relation to occupation, mean scores of total social support were higher among unemployed patients than work patients and no statistical significance differences between social support and its domains with occupation were found in which P - value > 0.05 (Table 6). The reason for this finding was related to the unemployed patients could be relied on a supportive social network as they suffered from worsening in physical, emotional and functional health and they obtained support especially from their family. These findings were in contrast with Kalhori[42] who found a significant relationship between perceived social support and job status.

The results of the current study revealed that the mean scores of QOL and subscales were higher among work patients than not working patients with no statistical significance

differences were found in which P - value > 0.05 (Table 7). This interpreted by the positive impact of work on QOL of depressed patients. This finding was in accordance with lua [43] which presented in the current study that employment has positive impact on quality of life than unemployment. At the same line, Salehi & Mahmodifar [44]) had found that no statististical significance between social support and work were found.

The present study reported that there was positive correlation between social support and QOL (r=.266, P=.007) (Table 8). This finding indicated that social support had impact on quality of life to further explain this impact; the distressing symptoms of depressive disorders can be alleviated by available social support which can improve the mental health of the studied sample and their quality of life. Similar findings reported by Wang [27] who mentioned that there were significant differences in the quality of life ($p < 0.01$) and perceived social support ($p < 0.01$) between the two groups and there was positively correlation between the quality of life and social support in depressed patients and he emphasized on the importance to provide the social support with a person with a depressed partner so that improving their quality of life. This result was in agreement with the study of Tai [26] while he found significant positive correlation between social support and QOL (r = .42, P< .01). These findings were in accordance with Emmanue et al., [45] who found that social support was a significant and consistent predictor of higher QOL scores. Sharir et al. [40] presented on his study that total social support was significantly related to total QOL ($p \leq .05$).

Conclusion

It was concluded from the current study results that the highest percentage of the depressed patients have low social support and QOL. It was concluded also that there were statistical significance differences between education level with QOL, physical health, social and personal relationships & the degree of self-reliance. There were positive associations between QoL and social support & all its subscales except self esteem support.

Recommendations

- Seminars and therapeutic intervention should be conducted to make the psychiatric patients aware the problems of social support telling them strategies to overcome these problems.
- Rehabilitation center for depressed patients and their families to engage them in society
- Increase awareness of the family of depressed patient about the importance of social support in treatment.
- Partnership programs for depressed patients to increase quality of life of depressed patients.
- Establishing educational centers and hot lines for family awareness about the importance of social support and quality of life for depressed patients.
- Future research studies should be done to detect therapeutic interventions and strategies to improve QOL and social support for depressed patients.
- Clinicians should therefore include QOL assessment as an important part of treating depression. More research is needed to examine the factors contributing to poor QOL in depressive disorders and to develop interventions to ameliorate it.

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