The Relationship Between the Depression Coping Self-Efficacy Level and Perceived Social Support Resources

Depresyonla Başa Çıkma Öz Yeterlik Düzeyi ile Algılanan Sosyal Destek Arasındaki İlişki

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SUMMARY

Objectives: The aim of this study was to determine the relationship between the depression coping self-efficacy level and perceived social support resources.

Methods: This study was planned as a descriptive and correlation research. The study population comprised 105 patients from acute psychiatric wards with a diagnosis of a major depressive disorder or episode; dysthymic disorder; bipolar I or II depressive episode; or adjustment disorder with depressive mood determined according to the DSM-IV diagnostic criteria. A questionnaire form, the Depression Coping Self-Efficacy Scale and the Multidimensional Scale of Perceived Social Support were used for the study.

Results: The Depression Coping Self-Efficacy Scale score of the population was 48.10±21.35 (min: 10, max: 97) and the Multidimensional Scale of Perceived Social Support score was 51.73±21.05 (Family: 18.04±8.71; Friends: 15.91±8.24; Special Person: 17.78±8.72). There was a positive correlation between the Depression Coping Self-Efficacy Scale and the Multidimensional Scale of Perceived Social Support (r=0.50; p<0.01).

Conclusion: This study is a contribution to the related literature since it demonstrates the relationship between the depression coping self-efficacy level and perceived social support resources of patients with depressive disorder. Self-efficacy and social support are important factors in the development and continuance of depression. Therefore, it is important that health professionals work with the family and spouses during the therapy in order to increase the level of social support for these individuals.

Key words: Coping; depression; self efficacy; social support.

ÖZET

Amaç: *Bu çalışmanın amacı, depresif hastaların depresyonla başa çıkmadaki öz yeterlik düzeyleri ile sosyal destek kaynaklarını algılama durumu arasındaki ilişkiyi belirlemektir.*

Gereç ve Yöntem: *Çalışma tanımlayıcı ve ilişki arayıcı bir çalışma olarak planlanmıştır. Araştırmanın örneklemini, akut psikiyatri kliniklerinde yatan, DSM IV tanı kriterlerine göre majör depresif bozukluk veya depresif dönem, distimik bozukluk, bipolar I veya II depresif dönem, depresif duygudurumlu uyum bozukluğu tanısı olan 105 hasta oluşturmuştur. Araştırmanın verileri; anket formu, Depresyonla Başa Çıkmada Öz Yeterlik Ölçeği ve Algılanan Sosyal Destek Ölçeği ile toplanmıştır.*

Bulgular: *Araştırma sonucunda, hastaların depresyonla başa çıkmada öz yeterlik puanları 48.10±21.35 (min: 10, maks: 97) ve Çok Boyutlu Algılanan Sosyal Destek Ölçeği puanı 51.73±21.05 bulunmuştur (Aile: 18.04±8.71; Arkadaş: 15.91±8.24; Özel bir kişi: 17.78±8.72). Depresyonla başa çıkmada öz yeterlik düzeyleri ile algılanan sosyal destek düzeyleri arasında pozitif yönlü bir ilişki vardır (r=0.50; p<0.01).*

Sonuç: *Mevcut çalışma depresyonla başaçıkma öz-yeterlik düzeyi ile algılanan sosyal destek arasındaki ilişkiyi göstererek literatüre katkı sağlamaktadır. Öz yeterlik ve sosyal destek depresyonun gelişiminde ve devamında önemli bir faktördür. Bundan dolayı bireylere sosyal desteği arttırmak için aile ve eşlerle çalışmak sağlık çalışanları için önemlidir.*

Anahtar sözcükler: *Başa çıkma; depresyon; öz yeterlik; sosyal destek.*

Introduction

Depression is one of the most common psychological problems adversely affecting the individual and resulting in loss of productivity, reduction in daily and professional functionality, financial difficulties, damage to interpersonal relationships or marriages, and even death.[1]

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In the coordinated study of the World Health Organization (WHO) conducted in 14 countries between 1989 to 1993, depression was diagnosed in 11.6% of the population in Turkey.[2] According to the study conducted by the Turkish Health Ministry (Mental Health Profile of Turkey), prevalence of depressive episodes was approximately 4% among 7429 people.[3]

There are several factors that have a role in the reduction or continuance of depressive symptoms, such as employment of appropriate coping strategies, self-efficacy, existence of social support, efficacy of anti-depressant medications, and the severity of depression.[4]

Coping is defined as a multidimensional process including cognitive, emotional and behavioral efforts to reduce psychosocial, emotional and physical distress associated with

difficulties encountered during daily life and distressful life activities. The extent to which the individuals experience depression and stress is related to their coping behaviors.[5,6]

One of the determinants of coping behaviors is self-efficacy. Individuals with a higher sense of self-efficacy tend to respond more insistently and positively to difficulties, demonstrate coherent and active coping behaviors, set higher targets for themselves, and have higher expectations of success. In contrast, individuals with lower self-efficacy levels tend to give up in the face of difficulties and experience high levels of depression and anxiety.[7,8]

Social support is an important determinant of high or low self-efficacy. Social support does not directly affect psychological health. It reduces the risk of psychological disorders by acting as a barrier when the individual is exposed to stress.[9]

Previous studies suggest that there is negative correlation between depression and social support, and that depression can be reduced with better social support. It has also been argued that social support affects perception of self-efficacy and indirectly develops the health and well-being of individuals.[10]

Supportive relationships not only improve the health of individuals, prevent health problems and provide a higher life satisfaction for individuals, they also protect individuals from the negative effects of stress by strengthening their coping mechanism, providing better health results, and positively affecting depressive symptoms.

The aim of this study was to determine the relationship between the depression coping self-efficacy level and perceived social support resources.

Questions addressed in this study included the following:

• Is there any correlation between the self-efficacy level in coping with depression and perceived level of social support?

• What is their perceived level of social support and the relation with individual and illness characteristics?

• What is their self-efficacy level in coping with depression and the relations with individual and illness characteristics?

Materials and Methods

Design

This study was planned as a descriptive and correlation research to determine the relationship between the depression coping self-efficacy level and perceived social support resources.

Setting

The research was carried out in a hospital that treats mentally ill patients. The hospital is characterized as the largest treatment and training hospital for mentally ill patients in Turkey and is affiliated with the Ministry of Health. There are ~1700 beds in the hospital. Patients admitted to 10 acute wards of this hospital were included in this study.

Sample

The study population comprised 105 depressed inpatients from the acute psychiatric wards of the hospital. The selection criteria for the participants were as follows: age over 18 years, and a diagnosis of a major depressive disorder or episode; dysthymic disorder; bipolar I or II depressive episode; adjustment disorder with depressive mood determined according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnostic criteria by a psychiatrist;[11] a lack of psychotic characteristics and developmental disorders; an ability to understand the presented scales; a willingness to participate in the interview; and hospitalization for a minimum of 48 hours.

Measurements

Questionnaire: A form was prepared by the researcher and consisted of questions regarding the individual and medical characteristics of the study population.[4,12]

The Depression Coping Self-Efficacy Scale (DCSES): The DCSES was designed to measure the self-efficacy beliefs that are related to the ability to carry out the tasks that are specific to coping with the symptoms of depression. The DCSES was developed by Perraud (2000) and consists of 24 items. The responses to the items are scored on a proportional scale that is divided into 10 equal ranges between 0% and 100%, the starting point of which corresponds to "not sure", the midpoint to "moderately sure", and the finishing point to "sure". The DCSES score is calculated as a percentage by dividing the sum of the points that are given to the scale items by the number of items. The higher the calculated percentage value, the higher the sense of self-efficacy. A score of <50% represents a low sense of self-efficacy, scores between 50% and 75% represent moderate self-efficacy, and a score of >75% represents a high sense of self-efficacy. Perraud (2000) tested the DCSES on individuals who had been diagnosed with depression, as well as on healthy individuals who had not been diagnosed with depression, and calculated Cronbach's alpha values of 0.93 and 0.84, respectively. There was a strong negative correlation (r=–0.73) between depression coping self-efficacy and depression.[4] The validity and reliability of the Turkish version of the scale were assessed by Albal et al. (2010). The DCSES scores were negatively correlated with the Beck Depression Inventory (BDI) score (r=–0.71, p<0.001). The alpha coefficient for the Turkish version of the DCSES was 0.94 for the main study, indicating a high degree of internal consistency. The test-retest reliability of the DCSES was 0.73. These results show that the DCSES has satisfactory reliability.[13]

Table 1. Correlations between the Beck Depression Inventory, Depression Coping Self-Efficacy Scale and Multidimensional Scale of Perceived Social Support

	DCSES		MSPSS	
	r	p	r	p
DCSES			0.50	p<0.01
MSPSS	0.50	p<0.01		

Table 2. Comparison of subgroups of the Multidimensional Scale of Perceived Social Support

Subgroups of MSPSS	Mean	SS	t	p
Family	18.04	8.71	2.350	<0.05
Friends	15.91	8.24		
Family	18.04	8.71	0.371	>0.05
Special Person	17.78	8.72		
Friends	15.91	8.24	2.14	<0.05
Special Person	17.78	8.72		

The Multidimensional Scale of Perceived Social Support (MSPSS): The MSPSS, which consists of 12 items, was developed by Zimet et al. (1988) to identify the social support factors perceived by the individuals. The scale is comprised of three groups depending on the source of support, each consisting of four items. These are family (3, 4, 8, 11), friends (6, 7, 9, 12) and a special person (1, 2, 5, 10). Each item is rated by using a 7-range scale varying between "definitely no" and "definitely yes". The sum of four items under each sub-scale gives the sub-scale score, while the sum of all sub-scale scores gives the overall scale score. The lowest score in sub-scales is 4 and the highest is 28. The lowest overall scale score is 12 and the highest is 84. The higher the score, the higher the perceived social support.[14]

The first translation and adaptation of the scale into Turkish was made by Eker & Arkar (1995), and the Cronbach alpha value was found to be 0.86.[15] Then, the psychometric characteristics of the form, which was reviewed by Eker, Arkar and Yaldız, were re-assessed and Cronbach alpha value was found as 0.89 for the entire study group.[16] The Cronbach alpha value of the scale was found to be 0.92 in this study.

Ethical Considerations

Ethical approval was granted by the research ethics committees of the involved hospital. The purpose and benefits of the research were explained to the participants prior to their inclusion into the study. Written and verbal consents were obtained from all participants and their anonymity was preserved.

Data Analysis

In explaining the distribution of sampling characteristics, frequency, average, standard deviation, median, minimum, and maximum were used. In statistical analysis of the data, Mann-Whitney U test (Zmw), Kruskal-Wallis test (Xkw), t test, one-way analysis of variance, and Spearman Rho Correlation test were utilized.

Results

The mean age of the participants was 38±11.71 years (range: 18-66 years). Of the sample, 55.2% were women and 44.8% were men.

The DCSES score of the population was 48.10±21.35 (min: 10, max: 97), and the MSPSS score was 51.73±21.05 (Family: 18.04±8.71; Friends: 15.91±8.24; Special Person: 17.78±8.72).

Table 1 shows the correlation between DCSES and MSPSS. A positive correlation was determined between DCSES and MSPSS (r=0.50; p<0.01).

A comparison between the MSPSS sub-groups of the patients is given in Table 2. When dual comparisons were made between the groups, a significant difference was determined between the family social support scores and friends social support scores (t=2.350; p<0.05), as well as between the friends social support scores and special person social support scores (t=2.136; p<0.05). It was found that the patients perceived their family and the special persons in their life as more socially supportive resources than their friends.

When the individual characteristics of the patients were compared regarding DCSES scores, the only significant difference in scores was determined with respect to sex and employment status (Table 3). When the individual characteristics of the patients were compared regarding MSPSS scores, there was a significant difference in MSPSS score with respect to marital status and definition of family (Table 3).

When the illness characteristics of the patients were compared regarding DCSES scores, there was significant difference in DCSES scores with respect to the number of relapses, length of hospitalization, suicidal ideation, and violence history (Table 4). When the illness characteristics of the patients were compared regarding MSPSS scores, there was a significant difference in MSPSS scores with respect to the length of hospitalization, suicidal ideation, and violence history (Table 4).

Discussion

Self-efficacy leads to positive results by acting as a mediator in the relationship between social support and coping behaviors.[17] This study demonstrated that the level of self-efficacy in coping with depression increased in conjunction with an increase in the level of perceived social support. Through a scan of the literature, previous studies conducted

among different populations regarding depression, self-efficacy, coping, and social support were examined, and it was found that self-efficacy had a positive effect on social support in preventing depression and contributed to an individual's psychological health.[17-19]

It was demonstrated in this study that patients perceived their family and the special persons in their life as more socially supportive resources than their friends. When the different studies were examined, it was seen that low social support was considered to be a risk factor for depression, while

Table 3. Comparison of individual characteristics according to the Depression Coping Self-Efficacy Scale and the Multidimensional Scale of Perceived Social Support

			DCSES				MSPSS			
Individual characteristics		**n**	**Mean rank**	**Zmw**	**Xkw**	**p**	**Mean rank**	**t**	**F**	**p**
Sex	Female	58	44.93	-3.415		<0.01	48.57	1.71		>0.05
	Male	47	62.96				55.64			
Education	Illiterate	5	49				60.40			
	Literate	2	31		3.69	>0.05	29.50		0.833	>0.05
	Primary school	41	56.17				54.12			
	Middle school	16	53.44				50.63			
	High school	25	47.12				51.00			
	University	16	57.63				47.94			
Marital status	Married	68	54.75	-0.904		>0.05	55.00	2.134		<0.05
	Single	37	49.78				45.73			
Family type	Nuclear	97	52.96	-0.055		>0.05	50.61	1.93		>0.05
	Traditional	8	53.50				65.38			
Family characteristics	Excessively protective	8	50.63				56.75			
	Excessively authoritarian	25	43.56		7.29	>0.05	41.16		8.930	<0.01
	Reassuring/supportive	56	59.43				59.71			
	Irrelevant family	16	46.44				37.81			
Work status	Working	19	68.68	-2.81		<0.01	55.79	1.025		>0.05
	Non-working	86	49.53				50.84			
Reason for not working	Disease-related	43	41.85	-0.72		>0.05	47.79	1.32		>0.05
	Not disease-related	43	45.15				53.88			

Table 4. Comparison of illness characteristics according to the Depression Coping Self-Efficacy Scale and the Multidimensional Scale of Perceived Social Support

			DCSES				MSPSS			
Illness characteristics		**n**	**Mean rank**	**Zmw**	**Xkw**	**p**	**Mean rank**	**t**	**F**	**p**
Length of illness	0-12 months	24	59.92				59.42			
	1-2 years	9	46.00		2.539	>0.05	49.11		1.608	>0.05
	2-3 years	9	48.44				44.44			
	>3 years	63	52.02				50.22			
Number of relapses	First time	17	69.18				64.76			
	Second time	20	54.60		8.994	<0.05	53.45		4.307	<0.01
	Third time	11	55.36				58.00			
	Fourth time or more	57	47.16				46.04			
Length of hospitalization	<1 week	17	62.59				53.94			
	1-2 weeks	29	52.66		12.727	<0.01	50.83		0.875	>0.05
	2-3 weeks	33	60.24				55.30			
	≥3 weeks	26	37.92				46.77			
Suicidal thoughts	Yes	98	51.37	-2.327		<0.01	50.72	2.672		<0.01
	No	7	75.86				65.86			
Violence history	Yes	41	43.024	-3.042		<0.01	43.51	3.4		<0.01
	No	64	59.391				57.00			

social support was suggested to reduce the risk of depression by reducing the effects of distressful situations.[18,20]

The findings of our study were similar to those of the studies we reviewed in the literature. On the basis of such results, we consider that a positive perception of social support will reduce depressive symptoms, and considering the high levels of perceived social support from the family, we suggest that the family is an important institution in the Turkish society in terms of social support.

Our study results revealed that there was significant difference between the characteristics of sex and employment status and self-efficacy levels in coping with depression. The fact that the self-efficacy scores of males were greater than of females in the study led us to consider that the social view of men and women as well as patterns of upbringing played a role in the results.

Major depressive disorder is the most common depression type encountered in individuals who have lost their job. Depression was associated with low self-respect, reduction in self-efficacy, unsuccessful job-seeking efforts, and dysfunctional behavioral patterns that result in continuance of unemployment.[21] The results of the study led us to consider that the individuals with high levels of self-efficacy were more functional in their professional lives, and that if the self-efficacy of individuals in depression could be increased, functionality within the society could also be increased.

Self-efficacy develops as a result of early-stage interactions between the individuals and their environment. Family, in particular, is an important factor in the development of self-efficacy. It is stated in the literature that the environment can contribute to developing coherent behaviors particularly in adolescents by supporting positive efficacy beliefs.[21]

The number of relapses and the length of hospitalization indicate the severity of chronic disorders such as depression. Therefore, it can be said that low self-efficacy will increase the number of relapses and length of hospitalization, both of which will have negative effects on self-efficacy. While there was a significant difference in the length of hospitalization, suicidal ideation and violence history with respect to self-efficacy levels in coping with depression, there was no difference between the lengths of illness. Future comparative studies with control groups may be suggested in this regard.

Our study revealed that individuals without suicidal thoughts had higher self-efficacy levels in coping with depression than those with suicidal thoughts. Dieserud et al. (2001) suggested that low self-efficacy was a concealed factor weakening interpersonal problem-solving abilities, causing the person to feel inefficient in problem-solving and thus leading to suicide attempts.[22] Perraud et al. (2006) found a negative correlation between the self-efficacy scale in coping with depression and suicidal thoughts scale.[12] The findings of our study were similar to those of Dieserud's and Peraud's studies.

Our study demonstrated that the self-efficacy levels of individuals with violence history were lower than those without violence history. The literature suggests that violence history and negative life experiences play an important role as preparatory factors for depression.[23]

When the personal characteristics and the levels of perceived social support in the study population were compared, there was a significant difference between the marital status of the patients and their definition of family and the levels of perceived social support, while there was no significant difference between age, sex, educational status, family characteristics, employment status, and reason for not working, and the levels of perceived social support. The fact that the married patients had higher levels of perceived social support than single patients led us to think that not only family but also spouses are an important source of social support.

The study results revealed that patients without suicidal thoughts had higher MSPSS scores than the patients with suicidal thoughts. In studies conducted among different groups, it was stated that low perception of social support was a preparatory factor for suicidal behaviors.[24-30] Despite being conducted among different groups, the studies we examined revealed similar results to ours, and it can be said that positive perception of social support is an effective factor in reducing depression and suicidal thoughts.

Conclusion

The aim of this study was to contribute to the literature by demonstrating the level of self-efficacy of depressive patients and their perceived social support in coping with depression. Self-efficacy is an important factor in the development and continuance of depression. According to the study, the self-efficacy scores of depressive patients were low in coping with depression. Since the data were collected within 48 hours following the hospitalization of the patients, the data were related to the most intense period of the disorder. Data related to the discharge period were not included. Self-efficacy does not have a stable structure. Therefore, attempts to increase self-efficacy of the individuals suffering from depression will help them cope with the disorder and achieve compliance.

The data for the study were collected from a sampling calculated according to the number of patients hospitalized in acute psychiatry clinics of a psychiatry hospital admitting the largest number of patients in Turkey. Therefore, it is difficult to generalize the study. Additionally, the findings were only evaluated on the basis of hospitalization data. Considering that self-efficacy can change over time, the efficacy of the hospitalization, treatment and care was not determined

in this study. It can be suggested that further studies should be conducted with control groups in relation to increasing the level of self-efficacy in coping with depression.

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