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Social support and sense of life in patients with anxiety disorders – preliminary report

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Summary

Aim. Verification of the level of social support perception and sense of life in patients with anxiety disorder and healthy people; evaluation of the relationship between these variables.

Method. *The Social Support Questionnaire* short version (F-SozU K-22) by G. Sommer and T. Fydrich and *the Life Attitude Profile* (LAP-R) by G.T. Reker were used.

Results. Social support and its dimensions prove to be significantly lower in patients with anxiety disorders. Healthy individuals have a higher sense of purpose, greater internal coherence, control of life, personal sense and balance of life attitudes, and lower intensity of existential emptiness. Higher emotional support and older age increase the level of sense of life in people with anxiety disorders.

Conclusions. For preventive and therapeutic purposes, it is important to develop and sustain the internal resources of the individual (sense of life and age-related experience). In patients with neurotic disorders, it also seems essential to use psychotherapy aimed at changing the patterns of personality that impede them from building social support networks. This is due to the fact that anxiety disorders are often characterized by lower confidence, avoidance of interpersonal relationships, falsified perception of social support, leading thus to distorted interpretation of supportive actions.

Key words: social support, sense of life, anxiety disorder

Introduction

Anxiety disorders, formerly called neurotic disorders, are a group of disorders associated with acute reactions to stress (ICD-10: F40–F48) [1]. They are marked by the individual's disproportionate defensive reaction to perceived reality, stemming from unrealistic judgment and not being a response to actual danger [2]. These disorders are

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often accompanied by anticipation anxieties, which manifest themselves in a fear concerning everyday life and make the individual's adaptive functioning more difficult [3].

Depending on the predominant symptoms, anxiety disorders are referred to as: mental (anxiety, depression, attention disorders), somatic (headaches, sleep, sensation, and movement disorders, breathing difficulties), or behavioral disorders (avoidance, compulsions) [1]. According to the statistical data published by the World Mental Health Survey Consortium, approximately 18% of the population of the United States aged over 18 suffered from anxiety disorders [4], and 23% of that group exhibited a high degree of these disorders (National Institute of Mental Health) [5]. It is estimated that approx. 14% of citizens in the countries of the European Union manifest acute disorder symptoms [6].

What plays an important role in the treatment of anxiety disorders is both pharmacotherapy and properly adjusted psychotherapeutic methods, leading to a significant reduction of symptoms [7]. From the psychological perspective, an important aspect in the functioning of individuals with anxiety disorders seems to be social support. It is a multidimensional concept. It is assumed that social support provides the individual with psychological and material resources in order to improve his or her skills of coping with stress [8]. The functions of support pertain to five areas: emotional (showing concern), informational (understanding the meaning), instrumental (specific ways of behaving), material (actual help), and spiritual help (enhancing the sense of meaning in suffering) [9]. Payne and Jones [10] call social support a complex process that is set in time, has a particular situational context, can be perceived by the patient as positive or negative, and comes from individuals or communities, close ones or strangers. The individuals who declare receiving support from others feel surrounded with care and love and rate their satisfaction with life as higher [11].

While research into the role of social support, particularly in individuals with depressive disorders [12, 13], has a well-documented history, there are few studies on sense of life in the context of anxiety disorders. Based on longitudinal research, Krause [14] observes that the higher is the anticipated social support (faith in receiving help in the future), the deeper the sense of meaning in life becomes. Debats [15] claims that although there are many factors with potential influence on the perception of sense of life, relationships with family and friends are particularly important. Steger et al. [16] emphasizes that the sense of meaning is positively related to social support in various stages of life. Machell et al. [17] argue that individuals with symptoms of depression experience higher sense of meaning in response to social interactions than depressed individuals who experience fewer interpersonal relationships. Weak social support is mentioned as a significant risk factor for depression recurrence [18].

Due to the small number of studies on support and sense of life in individuals with anxiety disorders, we attempted to formulate research questions that would concern differences in perceived social support and sense of life between patients with disorders and normal individuals, and that would make it possible to test the relations between these variables in the two groups. We hypothesized the following: there are

differences in all dimensions of perceived social support between disordered and normal individuals (hypothesis 1); the experience of anxiety disorders differentiates subjects in terms of the level of sense of life and existential attitudes (hypothesis 2); social support correlates positively with goal, internal consistency, life control, death acceptance, and goal seeking, and negatively with the sense of existential void (hypothesis 3); the level of personal sense of life in the total sample (hypothesis 4) as well as in subjects with anxiety disorders (hypothesis 5) depends on specific dimensions of social support and on age.

Material

The subjects in the study were 30 patients diagnosed with anxiety disorders (in accordance with ICD-10 diagnostic criteria), taking part in a group psychotherapy program (day-care wards) at the Department and Clinic of Psychiatry of the Pomeranian Medical University in Szczecin, Poland. The sample included individuals taking SSRI antidepressants (selective serotonin reuptake inhibitors – citalopram, escitalopram, paroxetine, fluoxetine, sertraline, and fluvoxamine). The patients were in different stages of psychotherapy, due to the fact that when a person completed it, another person started psychotherapy in his or her place. The shortest duration of psychotherapeutic interventions was 4 weeks and the longest duration was 12 weeks.

The clinical group included 11 men and 19 women, aged 21 to 59 ($M = 39.5$; $SD = 11.9$). The control group included individuals without anxiety disorders, aged 19 to 45 ($M = 28.0$; $SD = 7.2$). To select participants for the control group, we applied purposive sampling. The study was conducted with the respondents' consent; the respondents were ensured that the data they provided would be treated as confidential. The research project received approval from the Bioethical Committee of the Institute of Psychology of the University of Szczecin (KB 12/2017).

Method

In order to test the hypotheses, we used: *the Social Support Questionnaire* (F-SozU K-22) by G. Sommer and T. Fydrich (Polish adaptation: Z. Juczyński) and *the Life Attitude Profile-Revised* (LAP-R) by G. T. Reker (Polish adaptation: R. Klamut).

The F-SozU K-22 is an instrument for measuring three dimensions of social support: emotional support (perceived acceptance from others), practical support (help in everyday problems) and social integration (having a circle of friends) [19]. The respondent rates the extent to which he or she agrees with each of the 22 items by indicating the appropriate value on a scale from 1 ('completely untrue about me') to 5 ('completely true about me'). The measure of perceived social support is the sum score: the lower the score, the higher the support. Cronbach's α reliability for the total scale in the present study was 0.91 (emotional support $\alpha = 0.82$; practical support $\alpha = 0.84$; social integration $\alpha = 0.73$).

The LAP-R consists of 48 items and measures sense of life in terms of six categories of existential attitudes [20]: goal (orientation towards meaning and values), internal consistency (sense of identity), death acceptance (the understanding of the transitoriness of human nature), existential void (lack of a sense of influence on reality), life control (decision making or resignation from decisions in the context of responsibility for life), goal seeking (orientation towards development and taking up new challenges). The questionnaire also contains two compound scales: personal sense (a measure of sense of life) and equilibrium of life attitudes (sum score). The respondent rates the degree to which each item is true about him or her on a 7-point Likert scale (from 1 – 'totally untrue' to 7 – 'totally true'). Cronbach's alpha coefficient for the total scale was $\alpha = 0.84$ (goal $\alpha = 0.88$; internal consistency $\alpha = 0.86$; life control $\alpha = 0.83$; death acceptance $\alpha = 0.81$; existential void $\alpha = 0.68$; goal seeking $\alpha = 0.80$; personal sense $\alpha = 0.92$).

The statistical analyses necessary for testing the hypotheses were performed in IBM SPSS Statistics, version 23. We computed descriptive statistics for quantitative variables, tested the normality of their distributions and performed an analysis of correlations with Pearson's *r* coefficient and Student's *t*-tests for independent samples. We applied stepwise multiple regression analysis, with a significance threshold of $p < 0.05$. Results significant at $0.05 < p < 0.1$ were considered significant at the statistical tendency level.

Results

In accordance with the research aims, we began by investigating if the subjects suffering from anxiety disorders (the clinical group) differed from normal subjects (the control group) in terms of perceived social support (hypothesis1). The results of the comparison – namely, the values of arithmetic means (*M*) and standard deviations (*SD*) for particular dimensions as well as the values of Student's *t*-test, *p* levels of significance, and Cohen's *d* – are presented in Table 1.

We found that the compared groups differed significantly in the levels of emotional support, social integration, and social support, and also – at a tendency level – in terms of perceived practical support. The size of these effects is moderate. Normal subjects perceive a higher level of social support and its dimensions than anxious individuals.

Table 1. **The level of emotional support and its dimensions in the control group and in the clinical group**

	Control group (n = 34)		Clinical group (n = 30)				
	M	SD	M	SD	t	p	Cohen's d
Emotional support	28.15	5.17	23.43	6.93	3.052	0.004	0.778
Practical support	32.59	6.46	29.33	7.38	1.882	0.065	0.471

table continued on the next page

Social integration	29.15	5.49	26.37	5.31	2.054	0.044	0.514
Social support	89.88	15.42	79.13	17.76	2.592	0.012	0.649

Next, we tested whether the experience of anxiety disorders differentiated the subjects to a statistically significant degree in terms of the level of sense of life and the existential attitudes it comprises (hypothesis 2). The results of the analysis performed for this purpose with Student's *t*-test for independent samples revealed that the compared groups differed significantly in equilibrium of life attitudes and in the levels of the following dimensions: goal, internal consistency and personal sense. The size of these effects is high. We also found differences at a statistical tendency level – mainly in life control and existential void (the size of their effects is moderate). Normal subjects exhibited a higher level of goal, higher internal consistency, life control, personal sense, and equilibrium of life attitudes, and a lower level of existential void compared to individuals suffering from anxiety disorders (Table 2).

Table 2. **The level of sense of life and its dimensions in the control group and in the clinical group**

	Control group (n = 34)		Clinical group (n = 30)				
	M	SD	M	SD	t	p	Cohen's d
Goal	38.59	7.00	26.30	10.81	5.319	<0.001	1.367
Internal consistency	36.41	7.17	27.90	12.16	3.354	0.002	0.866
Life control	41.94	6.72	37.27	11.25	1.984	0.053	0.512
Death acceptance	33.29	8.66	29.93	12.29	1.249	0.217	0.320
Existential void	27.91	7.58	32.03	9.29	-1.953	0.055	0.489
Goal seeking	41.12	5.93	38.63	9.83	1.204	0.235	0.311
Personal sense	75.00	13.08	54.20	21.63	4.580	<0.001	1.182
Equilibrium of life attitudes	81.21	27.46	50.73	37.96	3.710	<0.001	0.929

In the next step, we tested if there was a relationship in subjects with anxiety disorders between sense of life and its dimensions and social support and its dimensions (hypothesis 3). Pearson's *r* correlation analysis (Table 3) revealed that various kinds of support correlated positively with goal, internal consistency, life control (only in one case), personal sense, and equilibrium of life attitudes, and negatively with death acceptance. Goal seeking was not correlated with any dimension of support.

Table 3. **Correlations of sense of life and its dimensions with social support and its components in individuals suffering from anxiety disorders**

	Emotional support	Practical support	Social integration	Social support
Goal	0.507**	0.311^{t}	0.415*	0.451*

table continued on the next page

Internal consistency	0.685**	0.529**	0.522***	0.643**
Life control	0.363*	0.238	0.170	0.291
Death acceptance	-0.230	-0.436*	-0.321	-0.367*
Existential void	-0.481**	-0.263	-0.425*	-0.424*
Goal seeking	0.162	0.238	0.031	0.172
Personal sense	0.638**	0.453*	0.501**	0.587***
Equilibrium of life attitudes	0.473**	0.190	0.328[t]	0.361*

* – $p < 0.05$; ** – $p < 0.01$; *** – $p < 0.001$; t – tendency

In order to deepen the discussed analyses, we investigated which variables made it possible to predict the level of personal sense of life in all subjects (hypothesis 4). For this purpose, we performed stepwise multiple regression analysis. The explanatory variables were support dimensions, sex, age, and group. The results show (Table 4) that the predictor which alone explained the highest percentage (47%) of variance in the level of sense of life was emotional support ($cR^2 = 0.468$; $R = 0.690$; $F(63,1) = 56.367$; $p = 0.001$). What was also of significance was the addition of further variables to the model, namely: age, sex and absence of anxiety disorders, which significantly increased the level of explained variance in the level of sense of life to 66% ($cR^2 = 0.660$; $R = 0.814$; $F(63,3) = 39.220$; $p = 0.001$). The values of β coefficient show that a higher level of emotional support, absence of anxiety disorders, and older age are potentially related to a higher level of sense of life.

Table 4. **Regression coefficients for personal sense of life as the dependent variable for the total sample**

	B	SE	β	R^2	ΔR^2	F_{change}
Model 1				0.47	0.46	56.36***
(Intercept)	8.83	7.74				
Emotional support	2.17	0.29	0.69***			
Model 2				0.55	0.54	10.74*
(Intercept)	23.58	8.48				
Emotional support	1.82	0.29	0.58***			
Absence of anxiety disorders	-12.18	3.71	-0.30*			
Model 3				0.66	0.64	19.11**
(Intercept)	-1.76	19.02				
Emotional support	2.02	0.52	0.64***			
Absence of anxiety disorders	-19.34	0.33	-0.47***			
Age	0.70	7.36	0.38***			

* – $p < 0.05$; ** – $p < 0.01$; *** – $p < 0.001$; B – non-standardized coefficient; SE – standard error of estimation; β – standardized coefficient; R^2 – multiple determination coefficient; ΔR2 – delta R^2; F_{change} – significance of F change

In the final stage, we investigated which explanatory variables were predictors of personal level of sense of life in individuals with anxiety disorders (hypothesis 5). The results show (Table 5), that the predictor explaining the highest percentage of sense of life (38%) is emotional support ($cR^2 = 0.386$; $R = 0.638$; $F(29,1) = 19.241$; $p = 0.001$).

Table 5. **Regression coefficients for personal sense of life as the dependent variable for subjects with anxiety disorders**

	B	SE	β	R^2	ΔR^2	F_{change}
Model 1				0.41	0.39	19.24**
(Intercept)	7.49	11.08				
Emotional support	1.99	0.45	0.64**			
Model 2				0.61	0.58	13.906**
(Intercept)	-35.85	14.80				
Emotional support	2.41	.39	0.77**			
Age	0.85	0.22	0.47**			

** – $p < 0.01$; B – non-standardized coefficient; SE – standard error of estimation; β – standardized coefficient; R^2 – multiple determination coefficient; ΔR2 – delta R^2; F_{change} – significance of F change

In Model 2, the percentage of explained variance in the dependent variable considerably increased, with a total of 58% in personal sense of life explained ($cR^2 = 0.580$; $R = 0.780$; $F(29,2) = 21.008$; $p = 0.001$). The values of β coefficient show that higher emotional support and age increase the level of sense of life in individuals with anxiety disorders.

Discussion

As postulated in the first hypothesis, subjects suffering from anxiety disorders differed from normal subjects in terms of perceived social support, the former rating this support as lower than the latter. Some of the earlier analyses provide support for these results. They revealed that patients diagnosed with social phobia declared lower social support than individuals belonging to the control group [21]. For example, Watson and Friend [22] claim that individuals with a high level of anxiety tend to feel lower anxiety, avoid interpersonal relationships, and worry more. Likewise, Haemmerlie et al. [23] mention the lack of interpersonal skills among the deficits distinguishing anxiety disorders. Staton and Campbell [24] observe that individuals with high anxiety may fall victim to distorted perception of social support, which may slow down or prevent their recovery. This kind of perception is usually accompanied by a distorted interpretation of supportive activities [25]. Aleksandrowicz [26] stresses that neurotic disorders are a form of communication aimed at satisfying psychosocial needs, which it is possible to satisfy only in a relationship with other people, by experiencing their presence, interest and love.

When testing the second hypothesis, we observed a lower level of sense of life and existential attitudes in patients with anxiety disorders than in normal individuals. Other correlational studies also revealed a negative relationship between sense of life and anxiety [27–29]. These reports can be considered from the perspective of existential psychology. Pathological anxiety reflects confusion or loss of sense of life [30], and the lack of a sense of meaning underlies many mental disorders [31]. Moreover, Bobkowicz-Lewartowska [32] notes that most people with neurotic disorders often negatively evaluate their life as a whole, not treating disease as an adaptive challenge and an opportunity for struggle but perceiving their condition in terms of failure.

The third hypothesis was also confirmed. The results are consistent with other analyses, proving that the dimensions of social support are positively associated with various aspects of sense of life and negatively with existential void. Krause [14] observed a similar pattern in an American longitudinal study of elderly people, in which sense of life correlated with perceived social support received from family members. These relationships can be explained in the context of research on the need to belong, which reveals that the sense of bond and finding fulfillment in close relationships enhances sense of life [33]. By contrast, the unfulfillment of this need, loneliness, isolation, and ostracism intensify the perception of life as pointless and worthless [34]. Moreover, as shown by numerous analyses worldwide, improvement in the functioning of people struggling with neurotic disorders requires the integration of many aspects of life, of which the most often mentioned ones are the sense of meaning and the stability of interpersonal relationships [35]. It should be noted that in the present study both the dimensions of support and the positive dimensions of sense of life were lower in the clinical group than in the control group. This may stem from the presence of both factors in various disorder-related experiences, when the lack of interpersonal relationships co-occurs with low sense of meaning.

In this context, what seems to be particularly significant for sense of life is emotional support (hypotheses 4 and 5). Support for these findings can be found in the study conducted by Krause [14]. Individuals who received emotional support reported higher sense of life than respondents who received only practical support. What is more, individuals who provided emotional support to the members of their community had higher a sense of life, which in turn led to health improvement. It is therefore possible to conclude that an important element of improvement in the functioning of anxious individuals is the need for a balanced approach to life in the context of illness. On the one hand, ill people need support; on the other, they can – as far as possible – support others. Mayeroff [36] emphasizes that receiving support and being useful (sharing one's skills or time) is a strong motivating factor regardless of age. The awareness of being useful can at least partly fill the existential void that appears in people with anxiety disorders.

In the present study, age also turned out to be a predictor of sense of life, though it should be remembered that the mean age in the sample was relatively high. In nu-

merous epidemiological studies conducted in various cultural contexts [37–39], the largest group among patients treated for anxiety disorders were young people aged 25–30. It is known that the influence of age on mental health may change in different developmental stages [40]. This is confirmed by reports indicating that the levels of stress and anxiety decrease with age, while the level of sense of life increases [41]. Also in cross-sectional studies sense of life was found to be positively related to the number of years the subjects had lived [36]. It is therefore legitimate to conclude that the sense of life remains an important psychological resource in illness in the period of middle adulthood [42].

Despite the consistency of results with the hypotheses and despite their empirical consistency with previous results obtained in other analyses, the present study is preliminary and has certain limitations. Due to the small size of the sample, model-based inference using regression analysis suggests a cautious interpretation, since in this kind of samples results may depend on a few observations rather than on the majority. For this reason, increasing the size of the group of subjects with anxiety disorders and further specifying its distribution of diagnoses would make it possible to determine the associations between types of support and the dimensions of sense of life more accurately. Moreover, although causal relationships are often considered to be inherent in regression analysis [43], in the present study it is difficult to specify the direction of the relationship between the final variables. It is not evident whether the lower level of social support in the population of subjects with anxiety disorders is a cause or an effect of the disorders. When low social support stems from disorder, enhancing support in this group of patients may lead to the reinforcement of dysfunctional ways of personality functioning. Finally, it should be stressed that the social support subjectively perceived by participants in the therapeutic group may not necessarily reflect the actual support they receive from other people. Therefore, the confirmation of the obtained results requires conducting further studies, with a methodology that would make it possible to compare perceived support with the support actually available.

Conclusions

1. An important factor in the therapeutic process of patients with anxiety disorders is the enhancement of sense of life (by enhancing its dimensions of goal, internal consistency, life control, death acceptance, and seeking personal sense) as well as striving to reduce existential void and the feeling of meaninglessness.
2. In the case of patients with neurotic disorders, it seems reasonable to apply psychotherapy aimed at changing those personality functioning schemas that prevent these patients from building a social support network. This stems from the fact that anxiety disorders are often characterized by lower trust, avoidance of interpersonal relationships, and distorted perceptions of social support, which leads to a distorted interpretation of supportive actions.

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