Illness Representations of Depression and Perceived Helpfulness of Social Support in Depressed and Never-Depressed Persons
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Objectives
The receipt of social support from family and friends has been found to buffer against the onset of depressive disorders and to facilitate recovery from a depressive episode (Gladstone et al., 2007; Slavich et al., 2009). However, social interactions between depressed persons and their social networks are characterized rather by lack of understanding and rejection towards depressed persons. For example, depressed persons perceive themselves as a source of supportive social ties and actually hold this lack of support responsible for hindering their recovery from depression (e.g., Gladstone et al., 2007). Research focusing on the perspective of the depressed persons' social network strongly corroborates the depressed persons' perceptions of disturbed social interactions as persons of the social network quite often react with avoidance and rejection towards depressed persons (Angermeyer & Matschinger, 2004; Helweg-Larsen et al., 2002). These interpersonal problems could be fostered by discrepancies between depressed and never-depressed persons' illness representations of depression and/or discrepancies in the perceived helpfulness of supportive behaviors. Therefore, the primarily goals of the study were to contrast depressed and never-depressed persons' illness representations of depression with regard to the representational attributes suggested by the self-regulation model (SRM, Leventhal et al., 1998) and to compare depressed persons' (recipients) and never-depressed persons' (potential providers) perceptions of the helpfulness of different social support behaviors.

Method

Depressed persons
N = 41 recruited from a psychiatry and a depression self help group
Depression status: PHQ score ≥ 10; M = 17.24 (SD = 4.16)
Age: 17-67 years, M = 49.56 years (SD = 10.40)
Gender: 18 (44%) males and 23 (56%) females
Living in a permanent relationship: 21 (51%)

Never-depressed persons
N = 58 recruited among visitors of a public library
Depression status: PHQ score < 10; M = 3.40 (SD = 2.21)
Age: 18-77 years, M = 42.69 years (SD = 10.40)
Gender: 23 (40%) males and 35 (60%) females
Living in a permanent relationship: 42 (72%)

Measures

Illness Representations
Ilness representations questionnaire revised (IPQ-R; Moss-Morris et al., 2002)
Subscales: timeline, consequences, personal control, treatment control, coherence, emotional representation, psychological attributions, risk factor attributions, immunity attributions, accident attribution, chance attribution

Perceived helpfulness of social support
Inventory of Social Support in Dyads (ISU-DYAD; Winkler & Klauser, 2003)
Subscales: emotional support, instrumental support, informational support
Inventory for Protection and Activation in Depression (ISAD; Dienst, 2009)
Subscales: activation-oriented support, protection-oriented support

Results

Comparing depressed and never-depressed persons on illness representations of depression

<table>
<thead>
<tr>
<th>Depressed persons</th>
<th>Never-depressed persons</th>
<th>F-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
</tr>
<tr>
<td>Timeline chronic</td>
<td>3.76 (5.11)</td>
<td>3.65 (5.54)</td>
</tr>
<tr>
<td>Consequences</td>
<td>4.04 (5.00)</td>
<td>3.93 (4.39)</td>
</tr>
<tr>
<td>Personal control</td>
<td>3.36 (7.77)</td>
<td>3.57 (8.88)</td>
</tr>
<tr>
<td>Treatment control</td>
<td>3.41 (5.57)</td>
<td>4.18 (5.46)</td>
</tr>
<tr>
<td>Illness coherence</td>
<td>3.06 (4.97)</td>
<td>2.96 (7.55)</td>
</tr>
<tr>
<td>Emotional representations</td>
<td>4.08 (5.99)</td>
<td>3.80 (4.47)</td>
</tr>
</tbody>
</table>

Psychological attributions | 4.08 (6.44) | 4.16 (4.86) | 0.42 |
Risk factor attributions | 2.66 (7.74) | 3.31 (5.56) | 22.29*** |
Immunity attributions | 2.04 (9.93) | 2.62 (9.50) | 9.12** |
Accident attribution | 2.16 (1.42) | 3.74 (1.10) | 35.44** |
Chance attribution | 2.14 (1.23) | 2.83 (1.02) | 8.67** |

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

Comparing depressed and never-depressed persons on perceptions of the helpfulness of social support

<table>
<thead>
<tr>
<th>Depressed persons</th>
<th>Never-depressed persons</th>
<th>F-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
</tr>
<tr>
<td>Emotional support</td>
<td>3.27 (3.9)</td>
<td>3.24 (3.2)</td>
</tr>
<tr>
<td>Instrumental support</td>
<td>3.16 (4.0)</td>
<td>3.03 (4.0)</td>
</tr>
<tr>
<td>Informational support</td>
<td>2.34 (5.4)</td>
<td>2.43 (4.0)</td>
</tr>
<tr>
<td>Action-oriented support</td>
<td>2.54 (6.3)</td>
<td>2.84 (3.9)</td>
</tr>
<tr>
<td>Protection-oriented support</td>
<td>2.83 (5.0)</td>
<td>2.55 (.93)</td>
</tr>
</tbody>
</table>

Note. ** p < .01

MANOVA with illness representations as dependent measures: F(6,89) = 11.80, p < .001, η2 = .44
with illness attributions as dependent measures: F(5,85) = 9.07, p < .001, η2 = .35
with social support behaviors as dependent measures: F(5,93) = 3.57, p < .01, η2 = .16

Discussion

As compared to depressed persons, never-depressed persons seem to underestimate the emotional impact of the illness and regard depression as a severe, but effectively treatable condition. These results support the assumption that never-depressed persons tend to minimize the seriousness of depression (Coyne et al., 1998; Kirk et al., 2000). Moreover, it was found that never-depressed persons had stronger beliefs that depression is also caused by external factors such as pollution and viruses than depressed persons, which might explain their stronger beliefs in treatment control. The existing discrepancies in illness representations could be a vital source for conflicts in social interactions between depressed persons and their social network as problem minimization by the support provider has been found to have negative effects on the recipient's well-being and social functioning (cf., Weinman, 2003).

With regard to the intended outcome of social support behaviors, it was found that depressed persons perceived protection-oriented support behavior as more active and activation-oriented support behavior as less helpful compared to never-depressed persons. These findings imply that depressed persons would rather like their social network to allow them to draw back and to express their sad mood, whereas never-depressed persons are more inclined to motivate a depressed person to actively approach his/her problems. Given this discrepancy, social support attempts will most likely end in failure as the supportive actions do not meet the needs of the depressed persons. In the long run, these unsuccessful support attempts of non-depressed friends could lead to frustration and to withdrawal from the depressed person (Winer et al., 1981).

In conclusion, discrepancies in illness representations of depression and perceptions of the helpfulness of social support do exist and may be the origin of problematic social interactions between depressed persons and persons of their social network. As the receipt of social support is an important determinant of recovery from a depressive episode, therapeutic interventions should strongly focus on social aspects and interpersonal consequences of depression. For this purpose, depressed patients should be advised of the fact that persons of their social network may have different perceptions of the illness and of the helpfulness of social support behaviors. Moreover, they should be encouraged to discuss this topic with family and friends to avoid misunderstanding and to facilitate supportive interactions.

References: