International Journal of Innovative Technologies in Social Science

e-ISSN: 2544-9435

Scholarly Publisher
RS Global Sp. z O.O.
ISNI: 0000 0004 8495 2390

Dolna 17, Warsaw,
Poland 00-773
+48 226 0 227 03
editorial_office@rsglobal.pl

ARTICLE TITLE	PERCEIVED SOCIAL SUPPORT AND AFFECTIVE DISORDERS: A COMPARISON OF INDIVIDUALS WITH DEPRESSION AND BIPOLAR DISORDER
DOI	https://doi.org/10.31435/ijitss.3(47).2025.3844
RECEIVED	28 July 2025
ACCEPTED	04 September 2025
PUBLISHED	24 September 2025
LICENSE	The article is licensed under a **Creative Commons Attribution 4.0 International License.**

PERCEIVED SOCIAL SUPPORT AND AFFECTIVE DISORDERS: A COMPARISON OF INDIVIDUALS WITH DEPRESSION AND BIPOLAR DISORDER

Piotr Łapiński *(Corresponding Author, Email: piotr.lapinski@gmail.com)*
MD, Central Clinical Hospital, Banacha 1A, 02-097 Warsaw, Poland
ORCID ID: 0009-0005-5740-3016

Jan Bombuy Gimenez
MD, District Health Center Ltd. in Otwock, Batorego 44, 05-400 Otwock, Poland
ORCID ID: 0009-0006-9217-5685

Maja Ćwiek
MD, Independent Public Complex of Health Care Facilities in Wyszków, Komisji Edukacji Narodowej 1, 07-200 Wyszków, Poland
ORCID ID: 0009-0009-2199-8555

Ignacy Sterliński
MD, Department of Hypertension, National Institute of Cardiology, Warsaw, Poland
ORCID ID: 0009-0008-7623-6403

Aleks Świderek
Student of Psychology Faculty, University of Warsaw, Warsaw, Poland
ORCID ID: 0009-0001-5084-7264

ABSTRACT

Background: Research on social functioning difficulties in individuals with bipolar disorder has produced inconsistent findings, ranging from significant social impairments to no differences or even superior outcomes compared to patients with depression. Current literature is limited by methodological constraints including use of non-validated self-report measures, lack of analysis of specific support sources, and absence of appropriate clinical comparison groups. These contradictory results necessitate investigation of alternative variables that may explain social support variations in affective disorders, which is crucial for developing targeted psychosocial interventions for bipolar disorder populations.
Methods: A quasi-experimental study recruited 89 participants (52 bipolar disorder, 37 depression) from online support groups across Polish, English, and Spanish-speaking populations. Perceived social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS). ANCOVA models controlled for age, gender, and psychiatric comorbidity.
Results: No significant differences emerged between diagnostic groups after controlling for covariates ($p > .05$). However, age was negatively correlated with global support ($p = .021$), friends support ($r = -.28$, $p < .007$), and significant other support ($r = -.23$, $p = .028$), while family support remained stable ($r = -.06$, $p = .555$). Both groups scored substantially below Polish population norms with large effect sizes (bipolar disorder: $d = -1.11$; depression: $d = -1.29$; $p < .001$).
Conclusions: Age, rather than diagnostic category, predicts perceived social support decline in affective disorders. Both groups demonstrate clinically meaningful social support deficits, suggesting common vulnerabilities requiring targeted interventions across affective disorder spectrum.

KEYWORDS

Bipolar Disorder, Depression, Perceived Social Support, Age Effects

CITATION

Piotr Łapiński, Jan Bombuy Gimenez, Maja Ćwiek, Ignacy Sterliński, Aleks Świderek (2025) Perceived Social Support and Affective Disorders: A Comparison of Individuals With Depression and Bipolar Disorder. *International Journal of Innovative Technologies in Social Science*. 3(47). doi: 10.31435/ijitss.3(47).2025.3844

1. Introduction

The analysis of the relationship between social support and mental disorders constitutes a significant health issue characterized by its complex nature and multidimensional research possibilities. Social support can influence symptom severity, mental illness relapses, serve as a tool for social and vocational rehabilitation, and significantly impact quality of life. Differences in the level of received social support also represent a social issue, as they may stem from societal perceptions of mentally ill individuals. The relationships between social support and affective disorders have been insufficiently examined to date. Given that individuals with bipolar disorder experience manic episodes, which are often associated with aggressive behaviors that disrupt others' functioning, it can be hypothesized that people with bipolar disorder represent a group.

1.1. Affective Disorders

1.1.1. Depression

Mood disorders are mental disorders that affect 14% of the population (Marneros, 2009). The main difference of bipolar disorder and depession, alongside depressive episodes, there are affective episodes of a different character than depressive ones. In the ICD-10 classification still used, symptoms of a depressive episode include anhedonia, sleep and appetite disturbances, decreased drive and mood, and cognitive symptoms such as memory and concentration problems. The course of depression also involves increased feelings of guilt, low self-esteem, fatigue, and suicidal thoughts and behaviors. Depression is diagnosed when symptoms persist for more than two weeks and significantly impact daily functioning. The pathophysiology of depression is complex and comprises genetic, environmental, immunological, endocrinological, and neurobiological factors (Jesulola et al., 2017).

1.1.2. Bipolar Disorder (ChAD)

Bipolar disorder is characterized by mood changes that take the form of episodes of varying duration depending on the disease subtype. The predominant character of episodes consists of depressive episodes, which constitute an average of 75% of affective episodes (Nierenberg et al., 2023). Additionally, manic, hypomanic, or mixed episodes can be distinguished. These are typically associated with elevated mood, except for the last type, where negative mood may co-occur with manic syndrome symptoms such as excessive activity, racing thoughts, or reduced need for sleep (Gałecki & Szulc, 2018, R. IX, pp. 189-236). The two predominant types of ChAD include: Type I, in which manic episodes occur, and Type II, in which hypomanic episodes occur. Classic mania is characterized by pathologically elevated mood, increased energy and activity, impulsivity, and decreased need for sleep. Psychotic symptoms may appear in both phases (Dunayevich et al., 2000).

1.2. Social Support

1.2.1. Definition and Typologies of Social Support

Social support refers to an individual's belief about being loved, valued, and belonging to a community characterized by mutual assistance (Cobb, 1976). The literature distinguishes four basic forms of support: emotional, instrumental, informational, and companionship (Langford et al., 1997). A key distinction is the division between behavioral support (actually received material and psychological help) and perceived support (subjective expectations regarding the availability of help, regardless of actually received support).

Barrera et al. (1983) identified six categories of supportive behaviors: material assistance (financial resources, objects), instrumental aid (sharing physical tasks), intimate relationships (conversations, showing care), guidance (providing advice and instructions), feedback (information about behaviors), and positive social interactions (recreational activities). Sources of support include family, friends, neighbors, social organizations, and institutions.

Research demonstrates moderate correlations between different dimensions of support. The type of support measured using the Inventory of Socially Supportive Behaviors correlates with measures of support

network size at a level of 18% shared variance, illustrating large discrepancies between objective measures of support and perceived support. Similarly, results obtained from questionnaires measuring received support and results from perceived support questionnaires share an average of 12% variance (Haber et al., 2007; Melrose et al., 2015).

1.2.2. Received Support

Received support is defined as material forms of assistance (goods, services) and immaterial forms of help (advice, showing respect) (Barrera et al., 1981). The Inventory of Socially Supportive Behaviors (ISSB) by Barrera et al. (1981) represents one of the first standardized measurement tools for support and contains 40 items assessing the frequency of receiving support in the past month.

One measure used in social support research that is closely related to received support is the social network, meaning social connections provided by the environment, which are evaluated in terms of structural (size, density, multidimensionality) and functional dimensions (Marsella & Snyder, 1981; Procidano & Heller, 1983).

1.2.3. Perceived Support

Perceived support is defined as "conveyed information leading a person to believe that they are loved, respected, and part of a network of communication and mutual obligations" (Cobb, 1976, p. 300). Alternatively, it can be understood as the degree of an individual's conviction about the satisfaction of their needs regarding support and feedback (Procidano & Heller, 1983).

Several questionnaires have been developed to measure perceived support, including the Multidimensional Scale of Perceived Social Support (MSPSS) by Zimet et al. (1988), characterized by its brevity (12 items), international adaptation, and division into sources of support (friends, family, significant other), and the Social Support Questionnaire (SSQ) by Sarason et al. (1983).

1.3. Social Support in The Context of Affective Disorders - Literature Review

1.3.1. Reduced Social Support in Individuals With Mental Disorders

Individuals with mental disorders have significantly lower levels of perceived social support compared to the general population. Shippee et al. (2011) in their research on the basis of analyze of demographic data and self-reported questionary from 2004 to 2006 collected by The Medical Expenditure Panel Survey, found that individuals with bipolar disorder demonstrated significantly greater social functioning impairments compared to those with depression and healthy controls, including higher rates of social limitations (26.2% vs. 14.0%), increased likelihood of living alone (37.6% vs. 25.6%), and substantially elevated odds ratios for „social restrictions” (OR = 5.17 vs. 2.85 for depression). The bipolar disorder population exhibited a distinct vulnerability profile characterized by reduced social resources, lower employment rates, and more severe functional limitations compared to the depression group. But, as a limitation of the survey, it should be noticed, that Shippee et al. (2011) only specify that social limitations were measured as restrictions „on participation in social, recreational, or family activities” without in-depth examinations or further explanation.

Maleki et al. (2019) provided a comparative study of 220 spouses, that revealed that caregivers of patients with bipolar I disorder experienced significantly greater burden than those caring for patients with major depressive disorder, with 85.5% reporting severe burden compared to only 11.8% in the depression group. Spouses of bipolar patients demonstrated substantially lower quality of life scores. In a meta-analysis by Studart-Botto et al. (2023), it was found that in individuals with bipolar disorder, even during the euthymic phase, three out of four studies showed significantly lower social support compared to control groups. Uygun et al. (2020) in a study of 90 patients with bipolar disorder and 30 individuals in the control group noted average perceived social support scores compared to the control group's, respectively. On the other hand, Poradowska-Trzos et al. (2007) reported, that in their comparative analysis of 80 patients, individuals with unipolar depressive disorder demonstrated significantly smaller social networks and support systems compared to those with bipolar disorder. Patients with unipolar depression received significantly less emotional support and showed lower overall support maintenance indices. Singh & Kishore (2018) in comparing individuals with mania and schizophrenia demonstrated significant differences, with individuals with schizophrenia receiving less support than those with mania. Similarly, in the case of patients with depression - according to a study by Soman et al. (2017) - it was found that social support in individuals with recurrent depression was significantly lower compared to individuals diagnosed with adjustment disorder.

1.3.2. Mechanisms of Reduced Social Support

Literature review supports a bidirectional relationship between symptoms of mental disorders and social support. Studart-Botto et al. (2023) emphasize that symptoms of dysfunction in individuals with bipolar disorder and reduced amounts of positive emotions may affect interpersonal relationships, while low perceived social support may in turn increase the risk of disease relapse. Uygun et al. (2020) observed that in the group of individuals with bipolar disorder, scores were significantly lower on the „partner" subscale and „friends", while family support did not differ between the bipolar disorder group and the control group. Beyer et al. (2003) in a comparative study on age-diverse groups of patients with bipolar disorder versus a control group demonstrated that patients with bipolar disorder only perceived their support as inadequate, regardless of demographic variables. Koenders et al. (2015) showed that perceived support was bidirectionally related to depressive symptoms, but not to manic symptoms, while manic symptoms specifically led to reduced actually received support. In summary, the literature review indicates a characteristic ladder of social support from the most severe disorders - schizophrenia, through bipolar disorder and depression to adjustment disorders. Some authors lean more toward the theory that dysfunction concerns perceived rather than received support, because according to Beyer et al. (2003). Romans & McPherson (1992) reached different conclusions, finding that individuals with bipolar disorder not only had reduced perceived support, but also received less support. Assessing the relationship between perceived and received support is difficult because received support that is inadequate (unsolicited, unexpected) could not change perceived support. Therefore, perceived support is considered a better indicator, as perceived support serves as a buffer in the course of affective disorders.

These methodological inconsistencies and varying findings underscore the necessity for continued research efforts for discovering important variables, which may explain this discrepancies.

1.3.3. Evidence for the Impact of Social Support on the Course of Mental Illness

Research systematically documents the significant impact of social support on the course of mental disorders, particularly regarding depression and bipolar disorder. Wang et al. (2018) in a systematic review of 34 studies showed that lower perceived social support predicts „greater symptom severity, lower chances of recovery, and worse social functioning in individuals with depression." Johnson et al. (2003) in a 12-month prospective study of 94 patients with bipolar disorder demonstrated that patients with lower levels of perceived social support had significantly higher risk of relapse and worse functioning between episodes.

1.4. Research Problem

Individuals with bipolar disorder experience manic episodes characterized by aggressive and socially disruptive behaviors in addition to depressive episodes. We hypothesized that individuals with depression would have greater social support than those with bipolar disorder. This hypothesis reflects differences in societal perception of these patient groups, which through bidirectional relationships results in reduced perceived social support among individuals with bipolar disorder. Comparing individuals with bipolar disorder and depression while analyzing sources of social support may clarify whether this results solely from cognitive symptoms or specific difficulties. Most studies lack adequate comparison groups of individuals with similar mental disorders, making them susceptible to „healthy user bias" and hindering understanding of the specific needs of individuals with bipolar disorder.

5. Methodology

5.1. Study Design

This quasi-experimental study compares naturally occurring clinical groups based on affective disorder type: bipolar and unipolar depression, regarding perceived social support. This design controls for the „healthy user bias" present when using healthy controls, as individuals with affective disorders provide more ecologically valid comparison groups regarding personal experiences and social functioning challenges.

5.2. Participants

Participants were recruited from Polish, English, and Spanish-speaking Facebook groups focused on psychology and affective disorders. Inclusion criteria were: clinical diagnosis of affective disorder (bipolar or unipolar), age ≥18 years, and approval of informed consent.

Between February and July 2025, 90 responses were collected, including 61 from Polish-speaking respondents, 17 from English-speaking respondents, and 12 from Spanish-speaking respondents, comprising 70 women, 14 men, and 6 others. The disproportionate representation of women in affective disorder research has been previously observed, with one study focusing exclusively on women (Romans & McPherson, 1992). Statistical pretesting was conducted prior to analysis (Table 1).

5.3. Measures

5.3.1. Dependent Variable

Perceived social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988). The MSPSS contains 12 items rated on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree), with higher scores indicating greater perceived social support. The scale demonstrates good psychometric properties (α = .88) and validity in psychiatric populations (Eker & Arkar, 1995).

5.3.2. Independent Variable

Affective disorder diagnosis was categorized as bipolar disorder or unipolar depression based on self-reported physician diagnosis.

5.3.3. Covariates

Demographic variables (age, gender) and comorbid mental health conditions were assessed through a custom demographic and health questionnaire.

5.4. Procedure

The study received approval from the Committee for the Ethics of Scientific Research Involving Human Subjects of the University of Warsaw on December 28, 2024 no 364/2024. The committee's adjudication was based on the principles of the Universal Declaration on Bioethics and Human Rights and the Guide for Members of Research Ethics Committees, issued by the Steering Committee on Bioethics on February 7, 2011, CDBI/INF(2011)2.

Following informed consent, participants completed the demographic questionnaire and MSPSS online. The study was conducted in compliance with EU General Data Protection Regulation (GDPR).

5.5. Statistical Analysis

Data normality was assessed using Shapiro-Wilk or Kolmogorov-Smirnov tests. For normally distributed data with homogeneous variance (Levene's test), independent samples t-tests compared groups. ANCOVA models controlled for demographic covariates. Additional analyses were planned for significant demographic effects.

Given that the majority of participants (67%) came from the Polish-speaking population, norms from the Polish adaptation of the MSPSS were selected (N = 1,322, M = 69.86, SD = 11.27; Buszman & Przybyła-Basista, 2017).

Table 1 Data Screening and Assumption Testing Procedures

Assumption/Check	Procedure/Test	Results	Decision/Action
Data Quality	Visual inspection of response patterns	One participant rated all MSPSS items at level 1	Excluded due to implausible responding
Missing Data	Case completeness inspection	All participants provided complete data	No imputation or deletion needed
Univariate Normality	Shapiro-Wilk test (α = .05), Q-Q plots	Global, Friends, Significant-Other: mild negative skew (Ws = 0.93–0.96, ps < .05); Family: W = 0.97, p = .074	Raw scores retained; HC3 standard errors applied
Homogeneity of Variance	Levene's test	All scales non-significant (ps ≥ .17)	Equal-variance assumption met
Linearity	Residual vs. fitted plots	No curvilinear patterns observed	Linear models appropriate
Homoscedasticity	Breusch-Pagan test	Non-significant with HC3 adjustment (ps > .20)	Assumption satisfied
Multicollinearity	Variance Inflation Factors	All VIFs: 1.02–1.45	No harmful multicollinearity (threshold < 5)
Covariance Equality	Box's M test	χ^2 = 28.3, p = .32	Assumption met for MANCOVA
Influential Cases	Cook's distance, studentized residuals	All Cook's D < 0.20; no residuals > |3|	No additional exclusions needed
Gender Categories	Orthogonal contrast coding	Six participants selected "Other"	Retained with contrast coding (Binary vs. Other)

Note. HC3 = heteroscedasticity-consistent standard errors; MSPSS = Multidimensional Scale of Perceived Social Support.

Results

Participants with bipolar disorder averaged 57.4, which is 12.5 points (approximately one full scale category) below the normative mean. Standardized, this corresponds to Cohen's $d = -1.11$, 95% CI [−1.38, −0.83]. A one-sample *t*-test against the population mean was highly significant, $t(51) = -7.97$, $p < .001$. In practical terms, the typical person with bipolar disorder in this study scored lower on overall perceived support than approximately 86% of the general Polish sample—a large negative deviation. The depression group's mean of 55.3 was even further from the norm, 14.6 points below. The associated effect size was $d = -1.29$, 95% CI [−1.61, −0.97]; the difference was again statistically significant, $t(36) = -7.86$, $p < .001$. This shift places the average depressed respondent below approximately 90% of their community peers on global support—a very large shortfall. Both mood disorder groups reported markedly weaker global social support than the Polish population standard. The magnitudes ($|d| \approx 1.1–1.3$) far exceed the conventional „large" threshold ($|d| = 0.80$), underscoring that diminished perceived support is not only statistically reliable but also clinically meaningful in both bipolar disorder and—especially—major depressive disorder.

Table 2. Means and Standard Deviations of Social-Support Scores by Diagnostic Group

Scale (range)	Bipolar *(n = 52)M* (*SD*)	Depression *(n = 37)M* (*SD*)
Global support (12–84)	57.4 (18.8)	55.3 (15.3)
Significant-other (4–28)	21.4 (7.0)	20.8 (7.6)
Friends (4–28)	18.8 (7.6)	19.8 (7.3)
Family (4–28)	17.3 (7.6)	14.7 (6.5)

Note. M = mean; *SD* = standard deviation. Higher scores reflect greater perceived support.

Table 3. ANCOVA Summary Predicting Social-Support Scores From Diagnosis, Age, Gender, and Other Diagnosis

Outcome	Predictor	*df*	*F*	*p*	Partial η²
Global support	Diagnosis	1, 83	3,11	.082	.04
	Age (years)	1, 83	5,96	*.017**	.07
	Gender	1, 83	2,55	.114	.03
	Other diagnosis	1, 83	0,69	.409	.01
Significant-other	Diagnosis	1, 83	0.19	.667	.00
	Age	1, 83	4,35	*.040**	.05
	Gender	1, 83	2,92	.091	.03
	Other diagnosis	1, 83	0.07	.803	.00
Friends	Diagnosis	1, 83	1,14	.289	.01
	Age	1, 83	4,36	*.040**	.05
	Gender	1, 83	2,92	.091	.03
	Other diagnosis	1, 83	0.07	.803	.00
Family	Diagnosis	1, 83	2,52	.116	.03
	Age	1, 83	2,32	.132	.03
	Gender	1, 83	0.52	.472	.01
	Other diagnosis	1, 83	1,88	.175	.02

Note. Diagnosis = bipolar disorder (reference) vs. unipolar depression; Gender was coded man, woman, other (retained in full); Other diagnosis = presence of any additional mental-health diagnosis. Robust HC3 standard errors were used; results are reported with two-tailed tests. Partial η² values ≥ .01, .06, and .14 can be interpreted as small, medium, and large effects, respectively (Cohen, 1988).

After adjusting for covariates, diagnostic group differences disappear – social support levels are statistically similar in unipolar depression and bipolar disorder. **Age** is a small but consistent negative predictor of social support (≈ 0.15–0.41 points per year, i.e. ~4–10 points over a 25-year span). Gender ("Other" included) and comorbidity do not reach significance and their removal does not change any conclusions. To better understand the relationship between age and perceived social support, MSPSS subscales were calculated, representing perceived social support scores divided by source: family, friends, and significant other.

Age was negatively correlated with perceived social support across three of the four MSPSS

Table 4. Pearson Correlations Between Age and Perceived Social Support

Scale (range)	**r**	***95 % CI for r***	***p***
Global support (12–84)	−.25	[−.43, −.04]	.021
Significant-other (4–28)	−.23	[−.42, −.03]	.028
Friends (4–28)	−.28	[−.46, −.08]	.007
Family (4–28)	−.06	[−.27, .15]	.555

Note. Negative correlations indicate that perceived support decreases with increasing age.

Only the family subscale shows no reliable linear trend. **Global support** showed a small negative association ($r = -.25$, $p = .021$), with participants reporting approximately 1 point lower support for every 2-3 years of age. **Friends support** demonstrated the strongest age-related decline ($r = -.28$, $p < .007$), indicating that friendship-based support diminished most notably with age. **Significant other support** showed a similar modest decline ($r = -.23$, $p = .028$). In contrast, **family support** remained stable across the lifespan ($r = -.06$, $p > .555$), showing no meaningful age-related trend. Effect sizes were small to medium ($|r| \approx .23–.28$), suggesting a gradual rather than dramatic decline in perceived support with age, with family support proving notably resilient to aging effects.

6. Discussion

The primary observed effect was a statistically significant negative correlation between age and perceived social support level, independent of affective disorder type. Additional analyses revealed that the deterioration of overall perceived social support with age resulted from decreased perceived support from both friends and significant others. These findings raise questions about the sources of the observed effect. Is the decline in perceived social support with age characteristic of individuals with affective disorders, the general population, or an artifact of the sample?

According to socioemotional selectivity theory predictions, as people age, they increasingly focus on emotionally meaningful goals and selectively regulate their social networks, maintaining close relationships while abandoning more peripheral contacts (Carstensen et al., 1992, 2000).

Research on social support changes with age in the general population shows that older adults have smaller social support networks, while the number of very close individuals remains relatively constant (Antonucci et al., 2004). Jiang et al. (2018) demonstrated that older adults are less inclined to directly seek social support from friends compared to young adults, which may translate to reduced perception of such support availability. Conversely, Li et al. (2011) in a study on support reciprocity showed that older adults reported more emotionally reciprocal friendships than young adults (33.7% vs. 21.3%), and friendships where they received more support than they gave proved most beneficial for life satisfaction in this group. In comparison, younger adults preferred symmetric relationships. Kafetsios and Sideridis (2006) demonstrated that young adults reported significantly more harmful social interactions than older adults (M = 4.16 vs. M = 1.63), while there were no differences in perceived positive social support between age groups. Based on cited studies in the general population, one can conclude that the number of people with whom social contacts are maintained decreases with age, while their quality increases through selective choice. However, no decline in perceived social support with age is observed. It should be noted that conducted research may depend partly on cultural influences and may differ between countries.

Turning to research on individuals with affective disorders, few studies directly address the questions posed in this discussion. Beyer et al. (2003) studied patients with bipolar disorder and showed that older patients with bipolar disorder perceived their social support as inadequate compared to healthy peers without

differences in social network size or number of social interactions. However, no significant differences were found between young and older individuals with bipolar disorder, suggesting that the negative impact of illness on social relationships manifests in younger patients and persists in older age. The Beyer et al. (2003) study was characterized by small clinical and control groups of approximately 30 individuals each and 56 individuals in the young bipolar disorder group. Romans and McPherson (1992) reached opposite conclusions, finding that patients with bipolar disorder showed significant negative correlations between age and all social interaction measures using the ISSI scale ($r = -0.26$ to -0.22, $p < 0.05$). Similarly, duration of bipolar disorder was negatively correlated with availability of social bonds and social integration ($r = -0.23$ to -0.28, $p < 0.05$). Importantly, patients with bipolar disorder had scores comparable to control group individuals with other psychiatric disorders (mainly depression—39 individuals), but significantly worse than mentally healthy individuals. The study was conducted on women and included 52 patients with bipolar disorder and a control group (N = 232). Both clinical group studies used questionnaires containing received and perceived support: Interview Schedule for Social Interaction (ISSI) and Duke Social Support Index (DSSI). In Romans and McPherson (1992), age led to deterioration of both received and perceived support in individuals with bipolar disorder, while in Beyer et al. (2003), individuals with bipolar disorder regardless of age had reduced perceived support only. The studies presented in the literature do not allow for unambiguous conclusions and indicate the need for further research. However, it is worth noting that populations with affective disorders and other mental disorders may be characterized by reduced perceived social support compared to the general population, which may result from both perception of support and objective difficulties in obtaining support.

The study that is the subject of this work sheds new light on the obtained results. The source of overall perceived social support deterioration was established as decreased perceived support from friends and significant others, while family support remained stable with age. The selective decline in support from two sources argues against exclusively cognitive bias in individuals with affective disorders. Perhaps according to socioemotional selectivity theory, individuals with affective disorders, requiring disproportionately more support than healthy individuals, are rejected by friends and romantic partners, which aligns with Li et al. (2011) findings that older individuals prefer maintaining relationships with those providing more support than with those needing support.

The lack of deterioration in perceived family support can be explained by the fact that family relationships result from kinship and affinity bonds and often shared living arrangements, making them more durable compared to friendships and romantic relationships, which more frequently involve peripheral or voluntary connections. Limited support levels from primarily friends and partners in individuals with bipolar disorder have been reported in the literature (Uygun et al., 2020).

The expectation that individuals with depression receive greater social support than those with bipolar disorder was not confirmed in the conducted study; however, the lack of observed main effect may result from study limitations rather than true absence of differences between groups.

6.1. Limitations

Several methodological limitations warrant consideration when interpreting these findings. First, the small sample sizes in study groups (52 bipolar disorder, 37 depression) increased the risk of Type II error, potentially masking truly existing differences between diagnostic groups. Consequently, although real differences may have existed, the limited sample may have prevented their detection in analyses.

Second, high psychiatric comorbidity (65% of participants) alongside the primary affective disorder diagnosis, combined with lack of differentiation in severity of primary illness and comorbid disorders, could have influenced study results. Although including the variable of other diagnosed mental disorders in the ANCOVA model did not yield a statistically significant relationship between support and affective disorder diagnosis, the group of individuals without additional mental disorders was small.

Third, the online questionnaire format may have introduced measurement bias, as it does not provide standardized, objective measurement conditions. Gender disproportions (79% women) and established differences in perceived social support between genders (Studart-Botto et al., 2023) may have contributed to reduced statistical power.

Fourth, recruitment through internet support groups may involve selection bias, as individuals active online may be more inclined to seek support, potentially translating to higher MSPSS questionnaire scores. This sample may not be fully representative of all individuals with affective disorders.

Finally, the study design did not allow assessment of participants' illness severity, which could be crucial for both the support they receive and their ability to objectively perceive available support. Individuals

experiencing more severe episodes may perceive their social support differently compared to those in remission or milder states (Johnson et al., 2000).

In summary, the results obtained in this study, while not confirming the initially assumed hypothesis, constitute an important supplement to knowledge regarding the role of demographic factors such as age in the dynamics of perceived social support in individuals with depression and bipolar disorder.

Conclusions

This study found that age, rather than diagnostic category, is the primary predictor of perceived social support decline in affective disorders. Both individuals with bipolar disorder and depression demonstrated clinically significant social support deficits compared to population norms, with age-related deterioration occurring specifically in friendships and romantic relationships while family support remained stable. These findings suggest that targeted interventions addressing age-related social support decline may benefit individuals across the affective disorder spectrum, with particular attention to maintaining non-familial relationships as patients age. Future research should examine longitudinal patterns and intervention strategies to preserve social connections in older adults with affective disorders.

Acknowledgments

The authors thank all participants who voluntarily participated in this study and the administrators of online support groups who facilitated recruitment. This research received no external funding. The authors declare no conflicts of interest.

REFERENCES

1. Antonucci, T., Akiyama, H., & Takahashi, K. (2004). Attachment and close relationships across the life span. Attachment and Human Development, 6(4), 353–370. https://doi.org/10.1080/1461673042000303136
2. Barrera, M., Jr., & Ainlay, S. L. (1983). The structure of social support: A conceptual and empirical analysis. Journal of Community Psychology, 11(2), 133–143. https://doi.org/10.1002/1520-6629(198304)11:2<133::aid-jcop2290110207>3.0.co;2-l
3. Barrera, M., Jr., Sandler, I. N., & Ramsay, T. B. (1981). Preliminary development of a scale of social support. American Journal of Community Psychology, 9(4), 435–447. https://doi.org/10.1007/BF00918174
4. Beyer, J. L., Kuchibhatla, M., Looney, C., Engstrom, E., Cassidy, F., & Krishnan, K. R. R. (2003). Social support in elderly patients with bipolar disorder. Bipolar Disorders, 5(1), 22–27. https://doi.org/10.1034/j.1399-5618.2003.00016.x
5. Buszman, K., & Przybyła-Basista, H. (2017). Polska adaptacja wielowymiarowej skali spostrzeganego wsparcia społecznego [Polish adaptation of the multidimensional scale of perceived social support]. Polskie Forum Psychologiczne, 22(4), 581–599. https://doi.org/10.14656/PFP20170404
6. Carstensen, L. L. (1992). Social and emotional patterns in adulthood: Support for socioemotional selectivity theory. Psychology and Aging, 7(3), 331–338. https://doi.org/10.1037//0882-7974.7.3.331
7. Carstensen, L. L., Pasupathi, M., Mayr, U., & Nesselroade, J. R. (2000). Emotional experience in everyday life across the adult life span. Journal of Personality and Social Psychology, 79(4), 644–655. https://doi.org/10.1037/0022-3514.79.4.644
8. Cassel, J. (1976). The contribution of the social environment to host resistance: The Fourth Wade Hampton Frost lecture. American Journal of Epidemiology, 104(2), 107–123. https://doi.org/10.1093/oxfordjournals.aje.a112281
9. Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38(5), 300–314. https://doi.org/10.1097/00006842-197609000-00003
10. Coury, M. S. (2009). Investigating the effects of depression and bipolar disorder on social support, stigmatization, and family burden [Master's thesis, University of Tennessee]. TRACE: Tennessee Research and Creative Exchange. https://trace.tennessee.edu/utk_gradthes/5691
11. Dunayevich, E., & Keck, P. E., Jr. (2000). Prevalence and description of psychotic features in bipolar mania. Current Psychiatry Reports, 2(4), 286–290. https://doi.org/10.1007/s11920-000-0069-4
12. Eker, D., & Arkar, H. (1995). Perceived social support: Psychometric properties of the MSPSS in normal and pathological groups in a developing country. Social Psychiatry and Psychiatric Epidemiology, 30(3), 121–126. https://doi.org/10.1007/BF00802040
13. Gałecki, P., & Szulc, A. (2018). Psychiatria [Psychiatry]. Edra Urban & Partner.
14. Haber, M. G., Cohen, J. L., Lucas, T., & Baltes, B. B. (2007). The relationship between self-reported received and perceived social support: A meta-analytic review. American Journal of Community Psychology, 39(1-2), 133–144. https://doi.org/10.1007/s10464-007-9100-9

15. Jesulola, E., Micalos, P., & Baguley, I. J. (2017). Understanding the pathophysiology of depression: From monoamines to the neurogenesis hypothesis model—are we there yet? Behavioural Brain Research, 341, 79–90. https://doi.org/10.1016/j.bbr.2017.12.025
16. Jiang, L., Drolet, A., & Kim, H. S. (2018). Age and social support seeking: Understanding the role of perceived social costs to others. Personality and Social Psychology Bulletin, 44(9), 1–13. https://doi.org/10.1177/0146167218760798
17. Johnson, L., Lundström, O., Åberg-Wistedt, A., & Mathé, A. A. (2003). Social support in bipolar disorder: Its relevance to remission and relapse. Bipolar Disorders, 5(2), 129–137. https://doi.org/10.1034/j.1399-5618.2003.00021.x
18. Johnson, S. L., Meyer, B., Winett, C., & Small, J. (2000). Social support and self-esteem predict changes in bipolar depression but not mania. Journal of Affective Disorders, 58(1), 79–86. https://doi.org/10.1016/S0165-0327(99)00133-0
19. Kafetsios, K., & Sideridis, G. D. (2006). Attachment, social support and well-being in young and older adults. Journal of Health Psychology, 11(6), 863–876. https://doi.org/10.1177/1359105306069084
20. Koenders, M. A., Giltay, E. J., Hoencamp, E., Elzinga, B. M., Spinhoven, P., & Spijker, A. T. (2015). The bidirectional impact of perceived and enacted support on mood in bipolar outpatients: A two-year prospective study. Comprehensive Psychiatry, 60, 59–67. https://doi.org/10.1016/j.comppsych.2015.03.009
21. Langford, C. P. H., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social support: A conceptual analysis. Journal of Advanced Nursing, 25(1), 95–100. https://doi.org/10.1046/j.1365-2648.1997.1997025095.x
22. Li, T., Fok, H. K., & Fung, H. H. (2011). Is reciprocity always beneficial? Age differences in the association between support balance and life satisfaction. Aging & Mental Health, 15(5), 541–547. https://doi.org/10.1080/13607863.2010.551340
23. Maleki, N., Sadeghian, E., Shamsaei, F., Tapak, L., & Ghaleiha, A. (2019). Comparative analysis of spouse's burden and quality of life in major depressive disorder and bipolar I disorder. Current Psychiatry Research and Reviews, 15(3), 193–198. https://doi.org/10.2174/1874464812666190819151039
24. Marneros, A. (2009). Mood disorders: Epidemiology and natural history. Psychiatry, 8(2), 52–55. https://doi.org/10.1016/j.mppsy.2008.10.022
25. Marsella, A. J., & Snyder, K. K. (1981). Stress, social supports, and schizophrenic disorders: Toward an interactional model. Schizophrenia Bulletin, 7(1), 152–163. https://doi.org/10.1093/schbul/7.1.152
26. Melrose, K. L., Brown, G. D., & Wood, A. M. (2015). When is received social support related to perceived support and well-being? When it is needed. Personality and Individual Differences, 77, 97–105. https://doi.org/10.1016/j.paid.2014.12.047
27. Nierenberg, A. A., Agustini, B., Köhler-Forsberg, O., Cusin, C., Katz, D., Sylvia, L. G., Peters, A., & Berk, M. (2023). Diagnosis and treatment of bipolar disorder. JAMA, 330(14), 1370. https://doi.org/10.1001/jama.2023.18588
28. Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan, C. A., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: From neurobiology to clinical practice. Psychiatry, 4(5), 35–40.
29. Pless, I. B., & Satterwhite, B. (1972). Chronic illness in childhood: A regional survey of care. Pediatrics, 50(6), 881–889.
30. Poradowska-Trzos, M., Dudek, D., Rogoz, M., & Zieba, A. (2007). Comparison of social networks of patients with unipolar and bipolar disease. Psychiatria Polska, 41(5), 665–677.
31. Procidano, M. E., & Heller, K. (1983). Measures of perceived social support from friends and from family: Three validation studies. American Journal of Community Psychology, 11(1), 1–24. https://doi.org/10.1007/BF00898416
32. Romans, S. E., & McPherson, H. M. (1992). The social networks of bipolar affective disorder patients. Journal of Affective Disorders, 25(4), 221–228. https://doi.org/10.1016/0165-0327(92)90079-L
33. Sarason, I. G., Levine, H. M., Basham, R. B., & Sarason, B. R. (1983). Assessing social support: The Social Support Questionnaire. Journal of Personality and Social Psychology, 44(1), 127–139. https://doi.org/10.1037/0022-3514.44.1.127
34. Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). Experimental and quasi-experimental designs for generalized causal inference. Houghton, Mifflin and Company.
35. Shippee, N. D., Shah, N. D., Williams, M. D., Moriarty, J. P., Frye, M. A., & Ziegenfuss, J. Y. (2011). Differences in demographic composition and in work, social, and functional limitations among the populations with unipolar depression and bipolar disorder: Results from a nationally representative sample. Health and Quality of Life Outcomes, 9, 90. https://doi.org/10.1186/1477-7525-9-90
36. Shrank, W. H., Patrick, A. R., & Brookhart, M. A. (2011). Healthy user and related biases in observational studies of preventive interventions: A primer for physicians. Journal of General Internal Medicine, 26(5), 546–550. https://doi.org/10.1007/s11606-010-1609-1
37. Siedlecki, K. L., Salthouse, T. A., Oishi, S., & Jeswani, S. (2013). The relationship between social support and subjective well-being across age. Social Indicators Research, 117(2), 561–576. https://doi.org/10.1007/s11205-013-0361-4

38. Singh, N. K., & Kishore, A. (2018). A comparative study of perceived social support among persons with schizophrenia and mania. Indian Journal of Psychiatric Social Work, 9(1), 24–28. https://doi.org/10.29120/IJPSW.2018.v9.i1.43
39. Soman, S., Bhat, S. M., Latha, K. S., & Praharaj, S. K. (2017). Do life events and social support vary across depressive disorders? Indian Journal of Psychological Medicine, 39(3), 316–322. https://doi.org/10.4103/0253-7176.207334
40. Studart, P. M., Bezerra Filho, S., Studart, A. B. D., Almeida, A. G. D., & Miranda-Scippa, Â. (2015). Social support and bipolar disorder. Archives of Clinical Psychiatry (São Paulo), 42(4), 95–99. https://doi.org/10.1590/0101-60830000000057
41. Studart-Botto, P., Léda-Rêgo, G., Abbade, P., Bandeira, I. D., & Miranda-Scippa, A. (2023). Social support among individuals with bipolar disorder during euthymic phase: A systematic review. Clinical Psychology & Psychotherapy, 30(2), 270–280. https://doi.org/10.1002/cpp.2805
42. Schulz, U., & Schwarzer, R. (2003). Soziale Unterstützung bei der Krankheitsbewältigung: Die Berliner Social Support Skalen (BSSS) [Social support in coping with illness: The Berlin Social Support Scales (BSSS)]. Diagnostica, 49(2), 73–82. https://doi.org/10.1026/0012-1924.49.2.73
43. Uygun, E., Cebeci, R. B., Özsoy, E., Başar, Ş., Erim, B. R., & Erkoç, N. Ş. (2020). Investigation of the relationship between perceived social support and psychological resilience in bipolar disorder: A cross-sectional study. Anatolian Journal of Psychiatry, 21(1), 37–44. https://doi.org/10.5455/apd.44293
44. Wang, J., Mann, F., Lloyd-Evans, B., Ma, R., & Johnson, S. (2018). Associations between loneliness and perceived social support and outcomes of mental health problems: A systematic review. BMC Psychiatry, 18, 156. https://doi.org/10.1186/s12888-018-1736-5
45. Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment, 52(1), 30–41. https://doi.org/10.1207/s15327752jpa5201_2