Supportive Psychotherapy for Enhancing Quality of Life among Patients with Depression

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Abstract

Major depressive disorder is the second leading disease causing functional impairment and disability. It is a prevalent health problem which is associated with diminished life quality, and significant physical and psychosocial impairment. Therefore, the current study aimed to enhance quality of life and decrease depressive symptoms for patients with depression through utilization of supportive psychotherapy. This study was conducted on 40 patients during their follow-up visits to the Outpatient Clinic, Al-Abbassia Mental Health Hospital. Data were collected using: 1) Interviewing questionnaire sheet including, socio-demographic data, history of depression and the patient's knowledge regarding depression. 2) Beck's Depression Inventory. 3) World Health Organization Quality of life Scale. The main result of this study showed that, there is a highly statistically significant difference between pre-post program implementation as regards patients knowledge about depression, level of depression and their total score of quality life domains. The study concluded that, utilization of supportive psychotherapy showed great enhancement of quality of life and decrease in depressive symptoms among patients with depression. The study recommended that the concept of supportive psychotherapy and quality of life should be integrated in nursing education curriculum to help nursing staff to guide patients with depression and their families on how to avoid and/or cope with depression to maintain normal life style at highest possible level of quality of life.

Key words: Depression – Quality of life – Supportive psychotherapy

INTRODUCTION

Major depressive disorder (MDD) is the second leading disease causing functional impairment, disability and workforce loss worldwide. It is a prevalent health problem which is associated with substantial mortality, direct medical cost, diminished life quality, and significant physical and psychosocial impairment. Currently, more than 140 million people around the world are suffering from depressive disorder **(Okasha, 2014).**

As reported by **WHO (2014)** MDD is sometimes referred as clinical or unipolar depression and is more intense than any of the other depressive disorders, with a prolonged duration of feelings of loss, hopelessness, and helplessness. Research suggests that unipolar depression is the most prevalent of all mental disorders. As reported in the Medical Outcome Study (MOS), patients with depression were found to function at a lower level and to have poorer well-being compared to patients with other chronic condition **(Wells, 2014).**

Depression negatively impacts a myriad of facets of an individual's life including functioning, satisfaction with work,

relationships, leisure, physical health, mental health, sexual functioning, sleep patterns, future outlook and overall sense of fulfillment or contentment with one's life. Studies have demonstrated that patients with MDD have significant impairments in quality of life (QOL). Consequently, there is a high need for effective treatment **(Trivedi et al., 2014).**

A growing body of evidence suggests that psychotherapy used in conjunction with medication gives better results in the patient's condition than either medication or psychotherapy alone **(Malan, 2012).** Supportive psychotherapy (SP) is the treatment of choice for severely impacted depressive patients who have a limited range of interests and activities, and improvised social worlds. The goal of SP is to help patients gain an understanding of conflicting relationship patterns in the context of supportive relationship **(Abbass, 2011).**

Hence, development of supportive psychotherapy program becomes an important element of psychiatric nursing management for helping the patients suffering from depression to improve adaptation by whatever means available and to teach depressed patients supportive techniques to help them to overcome symptoms of depression which consequently; improve their quality of life **(Connolly et al., 2012).**

Significance of the study

Depression has now become a universal health problem and the outcome of such disorder is physical, psychological, mental and social problems. Several studies have shown that depression results in impairment in the quality of life. Therefore, the aim of this study is to enhance quality of life and decrease depressive symptoms for patients with depression through utilization of supportive psychotherapy.

Nevertheless, there are no Egyptian nursing research studies that investigated the application of supportive psychotherapy with adult depressed patients. The current study would increase the knowledge about how depressed patients would benefit from supportive psychotherapy. In addition, it focuses on nursing care measures utilized through supportive psychotherapy that can be used in the future by psychiatric nurses in clinical settings for depressed patients.

Aim of the study

The aim of this study is to enhance quality of life and decrease depressive symptoms for patients with depression through utilization of supportive psychotherapy.

This aim was achieved through:

1. Assessing the severity of depressive symptoms of patients with depression.

2. Assessing the quality of life for patients with depression.

3. Accordingly, developing and implementing supportive psychotherapy program for meeting the identified needs of depressed patients to decreasing depressive symptoms and enhancing their quality of life.

4. Evaluating the effectiveness of supportive psychotherapy program on decreasing depressive symptoms and enhancing quality of life among depressed patients under study.

Hypothesis:

Depressed patients who participate in a supportive psychotherapy program will have better outcomes on their posttest scores regarding QOL and depressive symptoms.

MATERIAL AND METHODS

Technical design

Research design:

The present study is a quasi-experimental research designed for enhancement of quality of life among patients with depression.

Setting of the study:

This study was conducted at the outpatient clinics in Al-Abbassia Mental Health Hospital.

Subjects of the Study:

The subject of this study is a purposive included 40 patients during their follow-up visits to the previously mentioned setting according to the following criteria.

- Adult patients who were diagnosed as being major depressive disorder (MDD) according to the "International Classification of Diseases.

- Sex: both sexes (males and females)

- Free from other psychiatric disorders.

- Free from significant psychological co morbidities as psychotic depression, personality disorder and significant cognitive impairment (brain injury or dementia)

- Don't currently participate in any other type of psychotherapy.

Tools of Data Collection:

The data were collected by:

I.   Interview questionnaire sheet:

This questionnaire was constructed by the researcher after reviewing related literature in the field of depression. This interview questionnaire comprised three parts: The first part is concerned with the socio demographic characteristics of study subjects, which include, age, sex, marital status, level of education and occupation. The second part includes data related to patient's history of depression. The third part includes data related to patient's knowledge about depression.

Scoring system for knowledge related to depression:

The knowledge related to depression consists of 8 questions, the responses are scored from 0 to 1 (0) for incorrect answer and (1) for correct answer. Knowledge was considered satisfactory if percent was 50% or more and considered unsatisfactory if percent was less than 50%.

II.   Beck's Depression Inventory (BDI-II:

Beck's Depression Inventory was developed by a group of researchers [6]. The Beck Depression Inventory is a 21-items presented in multiple choice formats which measures the degree of depression in adults. Each of the 21-items of the BDI-II attempts to assess a specific symptom or attitude. Each category purports to describe a specific behavioral manifestation of depression and consists of a graded series of four self-evaluative statements.

Scoring system:

The statements are rank ordered to reflect the range of severity of the symptom from neutral to maximum severity. Each of the items consisted of 4 self-reported statements graded in severity from 0 (absent) to 3 (severe). None of the items were reverse-coded. The total scores were obtained by summing the scores from the 21 items to

arrive at scores ranging from 0 to 63. As reported in the BDI-II manual, the depressive symptoms scores are interpreted as:

- Normal: 0 – 10
- Minimal depression: 11 – 13
- Mild depression: 14 – 19
- Moderate depression: 20 – 28
- Severe depression: 29 – 40
- Extreme depression: Over 40

III. C- World Health Organization-Quality of Life (WHOQOL):

World Health Organization-Quality of Life (WHOQOL) is a standardized rating scale used to measure one's perceived QOL, developed by the **WHO (2008),** translated and modified by the researcher to measure QOL among patients with depression. It contains 26 items, 2 of them for overall quality of life (general QOL and general health) and 24 items distributed on four domains: the physical QOL domain, psychological QOL domain, social QOL domain and environmental QOL domain.

The four domains of quality of life:

- **Physical Health.** It contains 7 items and includes activities of daily living, dependence on medication, energy and fatigue, mobility, pain and discomfort, sleep and rest, and working capacity.

- **Psychological Health.** It contains 7 items and includes, self-esteem, body image, positive feelings, negative feelings, thinking, learning, memory and concentration, stress management, religion and personal beliefs

- **Social Relationships**. It contains 5 items and includes personal relationships, social activities, social support, leisure activities, and sexual activity.

- **Environment.** It contains 5 items and includes home environment, access to health services, financial resources, information and skills and opportunities for recreation.

Scoring system:

Each question from each domain of the scale was rated from 0 to 100 marks; all scores are oriented such that higher values denote better quality of life, after reversing the scoring for negative items, and the scores of each item were summed-up and the total divided by the number of items.

The quality of life levels for patients with depression was classified as the following:

- Poor: 0 – 33.3
- Average: 33.4 – 66.6
- Good: 66.7 – 100

Operational design:

This design includes description of the preparatory phase, pilot study, and implementation phase including field work, methods and procedures of the study, and design and implementation of the training program.

Preparatory Phase:

This phase was based on the following steps:

A. **Administrative design:** An official letter requesting permission to conduct the study was submitted from the Dean of the Faculty of Nursing, Ain Shams University to all responsible in charge in order to get the permission and cooperation for collection of data.

B. **Study tools:** The socio-demographic interview questionnaire sheet was constructed by the researcher and The

World Health Organization-Quality of Life was modified by the researcher under supervision of this research supervisors after extensive review of the previous and current, local and international related literature about the various aspects of the topics, using books, articles, periodicals and other available resources through the Internet.

C. Test validity and reliability

To achieve the criteria of trustworthiness of the tools of data collection in this study, the tools were tested and evaluated for their face and content validity, and reliability by a committee consisting of five experts from Faculty of Medicine and Faculty of Nursing, Ain Shams University. They were from different academic categories, i.e., professor and assistant professor. Different specialties were represented in the group such as Neuropsychiatric, Psychiatric/Mental Health Nursing. To ascertain relevance, clarity, and completeness of the tools experts elicited responses were either agree or disagree for the face validity; and for content reliability, important, not important, and comments.

The items on which most of the experts have agreed were included in the proposed tool and the required corrections and modifications were done.

The reliability of the tools that was assessed through measuring their internal consistency by determining Cronbach alpha coefficient, proved to be high as indicated in the following table:

Tools	Cronbach Alpha Coefficient		
	Scale reliability	Face validity	Statistical validity
Socio-demographic interview questionnaire	0.68	0.86	0.91
Quality of Life Scale	0.89	0.93	0.96

Pilot Study

A pilot study was performed before conducting the actual study and conducted on 5 patients as representing 10 % of total sample (later excluded from the main study subjects) to test and evaluate the clarity, feasibility and applicability of the research tools and in order to estimate the time needed to fill in the tools.

Implementing Phase:

- **Field Work:**

A supportive psychotherapy program was designed in Arabic language by the researcher after reviewing the related past and current, Arabic and English literature, using available books and articles to get acquainted with the research problem and develop the content of the program according to the current study needs.

Based on the pre-test of the study group using Sociodemographic Data Sheet, Beck's Inventory of depression-II, and QOL Questionnaire,

The following needs were detected among the study sample:

1- **Physical needs including**: Adequate nutrition, adequate sleeping and rest and physical exercise.

2- **Cognitive needs including**: Orientation with the disease nature and treatment and need to changing negative thoughts.

3- **Psychological needs including:** Development of a positive self-concept, expression of painful negative feelings, feeling loved and respected from others, need to cope with stressful life events and need to increase pleasant activities.

4- **Social needs including:** Positive social interaction and feeling of being useful.

The researcher tailored the content of the program to meet the current study needs and to suit participants' mental and physical status. For instance, the description of depression was simple in words, so that the patients can understand. The content of the supportive psychotherapy program was evaluated by a panel of expert professors in the field of the study including the supervisors of the work, in the light of their comments, the necessary modifications were carried out and the final form of the program was stated.

1- Implementing Phase:

Field work:

The actual fieldwork for the process of the data collection and implementation of the program has consumed eight months. The process of the data collection and implementation of the program was carried out in the period from the beginning of September 2014 to the end of April 2015 in the reception of Out-patient Clinics, in Al-Abbassia Mental Health Hospital through the following steps:

First step:

The researcher visited the selected setting two times per week on Saturdays and Thursdays from 8.00 a.m. - 4.00 p.m. The researcher met 50 patients who have met the inclusion criteria, 10 of them dropped out through the study, while the other 40 patients completed all the study sessions

Before starting the data collection, the researcher met with depressed patients after introducing herself, explained the nature and purpose of the study to seek participants' co-operation, emphasizing that all collected information is strictly confidential, then oral consent was obtained from them before the intervention method was applied.

Confidentiality of any obtained information was assured, and the subjects were informed about their right to participate or not in the study. The subjects were also assured about anonymity, and that data will only be used for the purpose of the study.

Second step:

The researcher interviewed with each patient individually to fill in the tools of data collection. Then the researcher explained the aim and objectives of the program to the patient, the researcher makes assure that all questions were completed. The tools of data collection were filled in by the patient or by the researcher when the patient was not educated. Filling in the tools lasted from 20-25 minutes for each subject included in the study.

Third step:

Application of the Supportive psychotherapy program

The supportive psychotherapy program was implemented in the form of sessions. The subjects were divided into 8 groups (4 groups on Saturdays and the other 4 groups on Thursdays) each group included 5 subjects. The content of the supportive psychotherapy program was achieved through 22 sessions covered in 6 theoretical sessions and 16 practical sessions. Theoretical part as definition, signs and symptoms, causes and complications of depression and practical part as changing negative thoughts, stress management, assertiveness techniques, promote self-esteem and relaxation techniques. Patients were interviewed and assessed before and after implementation of sessions to assess the effectiveness of supportive psychotherapy sessions on the depressed patients under study.

The supportive psychotherapy sessions implemented through three phases:

- **Introductory phase** (two sessions), in which acquaintance between the researcher and the study participants was made. Brief explanation about the study program contents and session schedule (time & duration) was given to the participants and oral informed consent from the study participants was obtained. The pre-test of the study instruments was done.

- **Working phase** (18 sessions), in which the researcher focused on working with the study groups using the techniques of supportive psychotherapy such as explaining, listening, encouraging and educating, also researcher used direct measures from different psychotherapies to ameliorate symptoms and to maintain, restore, or improve self-esteem, adaptive skills, and psychological function according to the study sample needs. These needs were clarified through the study pre-test of the study instruments. Each session ended by summarizing the session content to ensure the patients understanding. Simple explanation was the focus of the researcher to help each patient through the session.

- **Termination phase** (two sessions), in which the researcher terminated the supportive psychotherapy program and carried out the post-test of the study instruments for the study group.

At the beginning of each session, the researcher greeting the patients, giving them a feedback about the previous session and explained the objectives of the new topic to ensure that the patients understand the program contents. At the end of each session, questions were discussed to correct any misunderstanding. The researcher used different teaching methods and media such as; lectures, and open-group discussions. In addition, the researcher also used the role play, demonstration, re-demonstration, real life situations, colored posters, and handouts.

Ethical considerations:

After securing official requirement for caring out this study, the patients were informed about choosing to participate or not and about their right to withdraw at any time without giving a reason. Data were anonymous, and only used for the purpose of the study. The researcher explained the aim and nature of this study to the patients with reassurance about confidentiality of information given and that it will be used for scientific research only.

Statistical Design:

The statistical analysis of data was done by using the Computer Software for Excel Program and Statistical Package for Social Science (SPSS), version 16.0. Data were presented using descriptive statistics in the form of frequencies and percentages for categorical data and the arithmetic mean (X) and standard deviation (SD) for quantitative data. Qualitative variables were compared using chi square test (X) 2 and P-value to test association between two variables. The validity and reliability test was confirmed by using the Cronbach Alpha Coefficient test. Degrees of significance of results were:

- P-value > 0.05 Not significant (NS)
- P-value ≤ 0.05 Significant (S)
- P-value ≤ 0.001 Highly Significant (HS)

Result:

Table (1): represents the socio-demographic characteristics of the patients under study. It reveals that the mean age for the patients included in the study was 35.2 + **9.**3; three fifth of them (60%) was female. Concerning the marital status, slightly more than three fifths of them (62.5%) were single. In relation to the educational level of patients, two fifth of them (40%) can read and write, while 25% of them were illiterate and only 5% were university level.

Regarding to the working status of the patients under study, three fifth of them (60%) were not working and slightly more than half of them (52.5%) reside rural areas..

Table (2): reveals that three fifth of the patients (60%) were suffering from MDD from two years or more, while only 10% of them were receiving their medication for the same duration. As regards number of hospitalization, the majority of the study subjects (87.5%) were not hospitalized for MDD .The same table reveals that none of the patients previously participated in any type of psychotherapy.

Table (3): This table clarifies that there was an improvement in all items of knowledge about depression after program implementation compared to pre program implementation, and the total mean of knowledge increased in post program implementation from 14.7 + 5.1 to 25.3+9.5 with highly statistically significant difference (P< 0.01).

Table (4): reveals that a highly statistically significant difference was observed between before and after program implementation as regards total level of depression among depressed patients under study, where before program implementation three quarter of patients (75%) hade sever level of depression, versus a minority of them reported sever degree of depression after program implementation, representing 10.0% only.

Table (5): It's clear from this table that there is a highly statistically significant difference between pre/post program implementation as regards total score of quality life domains, where before program implementation the highest percentage 70% of the patients had poor level of quality of life, followed by 30% of the patients had average levels of quality of life, while none of patients was in good level of QOL, However, after the program implementation, there was obvious improvement in total score of QOL domains ,where the highest percentage 50% of the patients had average level of quality of life, followed by 32.5% of the patients had good level of quality of life, while 17.5 only of the patients had poor level of QOL.

Table (6): reveals that there were highly statistically significant relations before and after program implementation between patients' knowledge and their total score of quality of life, in which the highest mean scores of quality of life were detected among patients who have satisfactory knowledge about depression and the lowest mean scores of quality of life were detected among patients who have unsatisfactory knowledge about depression.

Table (7): reveals that there was a highly statistically significant relation before program implementation and a statistically significant relation after program implementation between level of depression and quality of life of depressed patients under study, in which the highest mean scores of quality of life were detected among patients who had mild level of depression and the lowest mean scores of quality of life were detected among patients who had sever level of depression at pre/post intervention.

Table 1: Socio-demographic characteristics of patients under study (n=40).

Items	Depressed Patients	
	No	%
Age (Years):		
21-<29	13	32.5
29-<40	15	37.5
40 +	12	30.0
Mean $\pm$ SD	35.2 $\pm$ 9.3	
Sex:		
Male	16	40
Female	24	60
Marital status:		
Single	25	62.5
Married	15	37.5
Divorced	0	0
Widowed	0	0
Level of education:		
Illiterate	10	25
Read & write	16	40
Primary & secondary school	12	30
University level	2	5
Work status:		
Working	16	40
Not working	24	60
Residence area:		
Urban	19	47.5
Rural	21	52.5

Table 2: Distribution of patients under study as regards their health history of MDD (n=40).

Health History of Depression	Depressed Patients	
	No.	%
Duration of disease (years)		
< 1	8	20
1 - < 2	8	20
2 +	24	60
Duration of medication taking (years)		
< 1	16	40
1 - < 2	20	50
2 +	4	10
Number of hospitalization for MDD		
None	35	87.5
Once	3	7.5
Twice	2	5
Previous participation in psychotherapy		
Yes	0	0
No	40	100

Table 3: Distribution of patients under study regarding their knowledge about MDD (n=40).

Item	Pre		Post		Test	
	Mean	**±SD**	**Mean**	**±SD**	**T**	**P**
Definition	1.5	1.2	3.1	1.6	4.8	< 0.01 HS
Causes	2.4	1.7	4.0	1.7	4.2	< 0.01 HS
Types	1.2	1.0	3.6	1.1	9.6	< 0.01 HS
Signs /Symptoms	2.9	0.7	3.4	1.4	2.0	> 0.05 S
Methods of treatment	1.4	0.7	2.6	1.1	6.1	< 0.01 HS
Complications	1.6	1.0	2.4	1.7	2.9	< 0.01 HS
Benefits of antidepressant drugs	3.0	1.7	3.9	1.6	2.4	< 0.05 NS
Benefits of psycho therapy	0.9	0.9	2.4	0.9	7.2	< 0.01 HS
Total	14.7	5.1	25.3	9.5	6.2	< 0.01 HS

Table 4: Distribution of depressed patients under study according to their total level of depression before and after program implementation (n=40).

Level of Depression	Pre		Post		Test	
	No	%	No	%	X^2	P
Minimal	0	0.0	8	20.0	39.6	> 0.01 HS
Mild	2	5.0	16	40.0		
Moderate	8	20.0	12	30.0		
Severe	30	75.0	4	10.0		

Table 5: Distribution of depressed patients under study according to their total score of quality of life domains before and after program implementation (n=40).

Quality of Life Domains	Pre						Post						Test	
	Poor		Average		Good		Poor		Average		Good		X^2	P
	No	%	No	%	No	%	No	%	No	%	No	%		
Physical Health	15	37.5	22	55.0	3	7.5	6	15.0	19	47.5	15	37.5	12.1	< 0.05 NS
Psychological Health	23	57.5	16	40.0	1	2.5	8	20.0	21	52.5	11	27.5	16.3	< 0.01 HS
Social Relationship	31	77.5	8	20.0	1	2.5	8	20.0	22	55.0	10	25.0	27.5	< 0.01 HS
Environment	17	42.5	15	37.5	8	20.0	6	15.0	20	50.0	14	35.0	7.6	< 0.05 S
Overall quality of life	29	72.5	8	20.0	3	7.5	9	22.5	17	42.5	14	35.0	20.9	< 0.01 HS
Total	28	70.0	12	30.0	0	0.0	7	17.5	20	50.0	13	32.5	27.6	< 0.01 HS

Table 6: Relations between patients' knowledge and their total score of quality of life before and after program implementation (n = 40).

Knowledge	Quality of Life		Test	
	Mean	+SD	T	P
Before Intervention				
Satisfactory	65.14	8.32	7.10	< 0.01 HS
Unsatisfactory	46.61	5.80		
After Intervention				
Satisfactory	100.30	4.20	3.30	< 0.01 HS
Unsatisfactory	94.80	4.60		

Table 7: Relations between the patients' level of depression and their total score of quality of life before and after program implementation (n= 40).

Level of Depression	Quality of Life		Test	
	Mean	+SD	T	P
Before Intervention				
Mild	52.9	9.7	4.90	< 0.01 HS
Moderate	42.5	2.1		
Severe	42.4	2.6		
After Intervention				
Minimal	100.1	4.5	3.90	< 0.05 S
Mild	101.2	4.1		
Moderate	96.0	5.4		
Severe	95.6	4.0		

DISCUSSION

The results of the present study revealed that the patients in the age group 29 ≤ 40 years constitute the highest percentage among depressed patients under study. This result may be due that, the highest percentage of the patients in the current study were single, and marriage often occurs after age of 20 years according to Egyptian society culture so, delayed age of marriage, lack of protective housing and loss of family or

social support contributing to depression. in addition, higher levels of depression and stress between married patients in this age group as reported by study subjects were due to impairment in their daily living including, interpersonal relationships with partners, children, family, and friends, and disruptions in their work. This result is consistent with the findings of several research studies as those of **Ghanem et al. (2009), Brown (2011), and Landen (2013)** whose study finding revealed that the incidence of MDD is highly noted between the ages of 25-45 years. As well, this finding goes in line with **Negash et al. (2013),** who conducted a study to investigate socio demographic correlates of depressive disorder in rural Ethiopia, their study revealed that age was associated with MDD, as those aged 30 and above had over twice the risk of those aged 25 or below.

As regards gender, the current study showed that three fifth of the patients were females; this may be due to that, women are socialized to experience and express distress with the type of thoughts, feelings and behaviors that are used to define clinical depression, also women are exposed to chronic gender specific stressors in their female social roles, as well as the multiple roles that women fulfill in society may contribute to the levels of everyday stress. Everyday stress and major life events have been found to be associated with the onset of depression.

These results were in accordance with a survey study conducted by the **WHO (2012)** to examine the gender differences in mental disorders across cohorts in 15 different countries from different regions of the world such as, the US, Lebanon and Brazil. The findings showed that in all cohorts and countries, women had more mood disorders, including MDD than men as reported by **Seedat et al. (2012)**. As well, this result is supported by **Hamid et al. (2013)**, who found that women overvalue relationships with others to the point that might be excessive and annoying which can make others reject them. Rejection and relationship conflicts increase women worries and can make them more vulnerable to depression.

In relation to marital status, finding of the current study revealed that slightly more than three fifth of the depressed patients under study was single. This may be due to lack of social support, lack of social interaction and lack of enjoyable life time and these explain the reason behind the powerful effect of marital status on depressive disorder, also, male patients in this study reported that, they delay or discourage marriage to avoid responsibilities of marriage due to their limited financial resources and unstable work condition, furthermore, being single was highly correlated with the development of depressive disorder.

The same result is found by **Gutierrez et al. (2013),** who reported that being single, is twice vulnerable to develop depression than being married. As well, **Huang et al. (2012)** studied socio-demographic and psychopathologic predictors of first incidence of DSM-IV mood and anxiety disorders. The study findings revealed that MDD was greater among single, separated, divorced, and widowed people.

Regarding the educational level, this study finding revealed that only 5% of the whole sample was university level and the rest were low educated, illiterate or just read and write. It might be due to that lower educated or illiterate individuals are quick to discontinue difficult processes, and are prone to higher levels of depression and stress. In contrast, higher educated individuals are performing and behave in ways that influence events affecting their lives. Such an outlook produces personal improvement, decreases stress, and reduces susceptibility to depression.

Another explanation is that this finding may be due to that all study subjects are recruited from Al Abassia Mental Health Hospital and most of the patients coming to this hospital are low socio-economic status, which is associated with low education and low income. Accordingly, low education and low salary or no income explain why those patients would be unable to facing every day stress, unable to seek professional help, unable to use and benefit from new health information and technologies and all these factors are contributing to depression.

This study finding is consistent with that reported by **Weich et al. (2014)**, who conducted a seven year longitudinal study on a Belgian sample to explore how socioeconomic factors can increase the risk for depression. The study indicated that low income and education were highly correlated and could increase the risk for depressive disorder. As well, **Deliege and Eaton (2013)**, concluded that low socio-economic status, particularly is consistently associated with higher prevalence of depression. A conflicting result was found by **White (2013),** which generates that majority of the patients studied were college graduates. This may be due to difference in the place of data collection.

As regards working status, this study result reveals that three fifth of the patients investigated in this study was not working. This could be due to that the highest percentages of patients in the current study are either low educated or illiterate. Accordingly, low education means few opportunities to find good jobs; also the consequences of MDD itself may lead to unemployment. This result is in agreement with **Landen (2013),** who found that more than two third of the study sample was not working and found stronger estimates between educational level, non- employment and low income and MDD.

A further explanation is, that, a relatively high percentage of the study sample are female and most of the female participants in the current study explained to the researcher that they did not work at any point in their life according to their customs and traditions, which limit the activity of women and confine their existence to the framework of the family. This result is in agreement with **Abou Zeid (2009)**, who explained that in Egypt, certain customs and traditions still generally defined women as dependants and are expected to be subordinate to men. Reproduction and childcare are generally seen as their primary responsibilities.

Regarding to the residence area of the patients, this study result indicates that slightly more than half of the patients under study were from rural areas; this may be due to low socioeconomic standards or due to shortage of psychological services in rural areas as reported by study subjects. This result is in agreement with **Brown (2011),** who reported that most of patients included in his study are residing rural areas. In addition**, Ghanem et al. (2009),** argued that the increase risk for mental disorders in rural areas compared to urban areas in Egypt may be a result of the poorer health services, which may be reflected in the greater numbers of undiscovered and /or untreated cases in these regions. Also, the differences in lifestyle and ability to tolerate stress may also result in increased risk of mental disorders in some regions. However, **Ghanem et al. (2009),** added that both the rural and urban areas in Egypt have specific problems that may contribute towards masking the difference. For instance, in urban areas, overcrowding, polluted environment and high levels of violence may affect the rates of mental disorder. Rural residents on the other hand, may face problems such as lack of proper infrastructure and low socioeconomic standards. On the other hand, **Kessler et al. (2013)**, stated that MDD was largely unrelated to geography (region of the country or urban city)

In short, this study results revealed that there is a set of individual characteristics that facilitated depression, including but not limited to age, being a woman, being single, unemployment and illiteracy or low education. These results are in accordance with many mental health studies **(Al-Issa, 2009; Ghanem et al., 2009; Miech & Shanahan, 2012; & Myers, 2013).** These studies indicated that, being a woman, being single, divorced, widowed and low education were highly correlated with the development of depressive disorder.

Regarding to duration of disease, this study result revealed that three fifth of the patients were suffering from depression for more than 2 years. This finding may be due to poor motivation to start therapy immediately after being diagnosed with MDD or may be due to poor medication adherence. This finding is in agreement with that of **Masand (2013),** who reported that duration of MDD among two third of the patients in his study was more than 2 years.

Regarding to duration of medication taking in the current study, half of the patients were taking their medication from one year to less than 2 years. This could be explained as although having MDD since 2 years or more but they did not start therapy immediately after being diagnosed with MDD. Also, many patients stated that some of their family members mistreated them and considered them stigma and burden to the family. This finding corresponds with that of **Kessler (2011),** who found that the patients in his study were taking their medication for less than 2 years.

Regarding number of hospitalizations for depression, the majority of the study subjects were not hospitalized for MDD .This is consistent with **Muscatell et al. (2012**) who reported that most of patients with MDD are treated in outpatients clinics and not hospitalized for MDD. A different result was found by **Angest and Preisig (2012**), who

found that, most of patients with MDD had more recurrent admissions to mental health hospitals due to recurrent relapse of depression.

Concerning the previous participation in psychotherapy, the present study result revealed that none of the patients participated previously in any type of psychotherapy. This finding may be due to no application of psychotherapy with depressed outpatients in Al-Abbasia Mental Health Hospital. This result agreed with that of **Hendriksen (2012),** who found that most of the patients in his study did not receive any type of psychotherapy.

The present study finding indicates that there was an improvement in the total knowledge of depressed patients under study after program implementation compared to pre- program implementation, where the majority of depressed patients under study had unsatisfactory knowledge about MDD pre- program implementation. This could be due to that the patients investigated did not previously receive health education about MDD. On the other hand, the improvement in total knowledge of depressed patients understudy after program implementation may be due to transferring knowledge about MDD through implementation of supportive psychotherapy program which help depressed patient to come to terms with their condition and to take care of themselves.

These findings agree with the results of **Brown (2011) and Dekker (2013)** who found that, the healthcare professionals are responsible for giving knowledge to the person with an illness and their family, in order to support their understanding of the condition and their involvement in their care. These efforts help the patients to facilitate changes in lifestyle and health habits and embedded in the person's quality of life. However, this finding is not in accordance with **Abdel Hamid (2012),** who found in his study that most of patients with MDD are

highly educated and had satisfactory knowledge about MDD.

Concerning total level of depression, this study result reveals that a highly statistically significant difference was observed before and after program implementation as regards total level of depression among depressed patients under study, where pre program three quarter of patients have sever level of depression, versus a minority of patients reported sever degree of depression after program implementation. Sever level of depression before program implementation may be due to poor medication adherence, prescription of inappropriate medications or inadequate dosage, lack of follow-up care plans, poor motivation to continue therapy failure to perceive benefit of ADDs or lack of coping skills to deal with depressive symptoms.

However, improvement after program implementation could be due to the fact that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. These findings agree with the results of **Hendriksen et al. (2012),** who conducted a mega-analysis to examine the efficacy of SP in the treatment of MDD. The results of the mega-analysis suggest that combined therapy is more efficacious than pharmacotherapy in term of symptoms reduction and quality of life improvement.

The current study is primarily established to enhancement of quality of life of the patients with MDD including physical health, psychological health, social relationship, environment and overall quality of life. To achieve the aim of the study, a specialized scale was used to assess the quality of life level of such group of patients.

As regards physical health, this study finding revealed that there were highly statistically significant relations between pre and post program implementation as regards

total physical health of depressed patients under study.

Whereas, before the program implementation the mean score of all items of physical health were low and the lowest mean of physical health was for sleep quality. This result was approved by **Xiao (2013),** who conducted a research study to evaluate the attitudes on sleep and sleep disturbances pre- and post-antidepressant treatments in patients with MDD. The findings indicated that depressive symptoms were alleviated significantly, whereas sleep disturbance persisted. Contradicting to this finding, **Nenclares et al. (2013)** carried out a research study to examine sleep quality in depressed patients. The findings indicated that there is no association between sleep quality and severity of depressive symptoms.

In relation to psychological health, this study finding revealed that there is a highly statistically significant difference between pre and post program implementation as regards total psychological health of depressed patients under study, were all items of psychological health improved after program implementation. This may be due to the application of supportive psychotherapy program which included actions directed toward symptom reductions such as; expression of feelings, stress management, self-esteem enhancement strategies, practicing thought stopping strategies and assisting the patient to identify cognitive errors which helped the depressed patients to develop healthy coping response and improve psychological health.

This finding agreed with **Bortolotti et al. (2013),** who mentioned that psychological intervention can participate in the prevention and treatment of depression and can promote a return to normal mood and effective functioning for most patients with affective disorders.

Concerning social relationship, this study finding revealed that there is a highly statistically significant difference between pre and post program implementation as regards social relationship of depressed patients under study. Where before program implementation, there is a greater impairment in social relation such as; a low level of social support, maladjustment in social and leisure activities, and poor quality of relationships.

This finding is congruent with the results of **Hoyt et al., (2014),** who reported that the association between depression and impaired social functioning has long been recognized, and it is acknowledged that recovery from depression requires not only the resolution of depressive symptoms but also an improvement in the interaction of the individual with his/her environment. On the other hand, there is significant improvement in personal relationship, social support, and leisure activities after the program implementation.

These findings can be due to the effect of supportive psychotherapy program on enhancing the personal relationship through helping the patients to acquire the necessary skills needed for coping with emotionally charged situations and escalate, using verbal and nonverbal communication skills, assertiveness training, teaching them how to handle stressful life events, and encouraging patients to increasing social and leisure activities. This result is supported by **Joyce (2012),** who denoted that, increasing social and leisure activities and proper support network showed improvement in patient's depression and quality of life.

The present study result also clarified that a highly statistically significant difference was observed before and after program implementation as regards environmental domain of QOL, and the lowest mean score of environmental domain before program implementation was for

opportunities for acquiring new information and skills. This finding could be related to that the majority of the current study sample was low educated. Accordingly, lower education means few opportunities to benefit from new health information and technologies, which make life easier more generally and reduce stress.

As well, this result may be due to inadequate patients' education about the necessary skills needed for coping with their illness. This finding is consistent with that of **Bothwell (2012),** who found that most of the patients in his study had few opportunities for acquiring new information and skills due to poor motivation to continue therapy and lack of social support network as consequence of their illness.

The current study finding revealed that there is a highly statistically significant difference between pre-post program implementation as regards total score of quality life domains, where before program implementation the highest percentage of the patients had poor level of quality of life and none of them was in good level of QOL, while after the program implementation, there is obvious improvement in total score of QOL quality of life domains, where the highest percentage of the patients had average level of quality of life, while only a minority of the them was in poor level of QOL.

Before program implementation the highest percentage of the patients had poor level of quality of life and none of them was in good level of QOL, this could be due to the consequences of MDD itself, severity of depressive symptoms, presence of psychological, social, financial factors and characteristics of the patients under study.

This result is supported by **Wells (2014),** who reported that, patients with depression were found to function at a lower level and to have poorer well-being

compared to patients with other chronic conditions. In addition, Diamond and **Becker (2012),** found in their study that quality of life is negatively associated with the level of depression for patients with mental illnesses. As well, this finding is in agreement with **Casacalenda (2014),** who mentioned that scores of QOL worsen with MDD due to that depressive symptoms frighten people and therefore people with MDD tend to become stigmatized or rejected.

On the other hand, there is significant improvement in total score of quality of life after the program implementation; it might be attributed to the actions directed toward symptom reductions such as; medication use and psychotherapeutic intervention as teaching the patients a set of comprehensive skills necessary to improve one's ability to generate more positive future experiences and increasing the patients' knowledge and skills about coping strategies to deal with environmental situations and psychosocial factors that accelerate negative emotions as anger, frustration, anxiety, boredom, grief etc.

These coping strategies include stress management skills, assertiveness training, relaxation techniques, and skills needed for enhancing self-efficacy, which are necessary to improve the quality of life of patients with depression. Similarly, **Benner and Wrubel (2013)** reported that the main goal of the psychotherapy intervention is to assist and enhance the person's ability to develop into the persons they want to be, and the healthcare professionals are responsible for giving knowledge to the persons with an illness, and their families, in order to support their understanding of the condition and their involvement. These efforts help the patients to facilitate changes in lifestyle and health habits and enhance their quality of life.

Regarding the relations between the patients' knowledge and their total score of quality of life before and after program implementation, this study result revealed

that there were highly statistically significant relations before and after program implementation between patients' knowledge and their total score of quality of life, in which the highest mean score of quality of life was detected among patients who have satisfactory knowledge about depression and the lowest mean score of quality of life was detected among patients who have unsatisfactory knowledge about depression.

This finding demonstrates that knowledge about the condition and how to live with it are strengthening persons with MDD in finding a way in which to manage with the condition and their lives and achieve better quality of life. This result was supported by that of a recent study carried out by **Peselow (2014),** who reported that knowledge of the patients about their disease will encourage them to make informed choices, and achieve better quality of life and personal control on their problems. As well, these results are in agreement with **Berlim (2014),** who reported that, healthcare professionals are responsible for giving knowledge to the persons with an illness and their families, in order to support their understanding of the condition and their involvement in their care. These efforts help the patients to facilitate changes in lifestyle and health habits and embedded in the persons' quality of life.

As regards the relations between the patients' level of depression and their total score of quality of life before and after program implementation, this study result revealed that there was a highly statistically significant relation before program implementation and statistically significant relations after program implementation between level of depression and quality of life of depressed patients under study, in which the highest mean score of quality of life was detected among patients who have mild level of depression and the lowest mean score of quality of life was detected among patients who have sever level of depression.

This may be due to the fact that, reducing depressive symptoms was the largest predictor of change in QOL and the depressive symptoms having a major role in the lowered QOL.

The findings in this present study are consistent with those of several studies carried out by **De Almeida et al. (2010); Reed et al. (2011) and Berlim (2014),** those studies results showing significant impairment of QOL in MDD patients with severe depressive symptoms.

Comprehensively, the results of the current study support the research hypothesis and the many past research findings and indicated that supportive psychotherapy had positive impact on depression scores and QOL. As well, **Menchetti et al. (2012),** revealed similar results in meta-analytic review of 10 randomized controlled trials to examine the effect of psychological interventions for MDD; the study result indicated that psychological interventions including supportive psychotherapy have a significant positive effect on patient's depressive symptoms and quality of life. In conclusion, the use of supportive psychotherapy with patients with MDD in outpatient clinics was effective in reducing their depressive symptoms, and enhancing their quality of life.

In addition **Dekker (2013),** compared the effect of adding psychotherapy to psychopharmacology in the treatment of MDD. The results indicated significant improvements in both, the patients' depressive symptoms and social and psychological functions when compared to the use of psychotherapy or psychopharmacology alone.

CONCLUSION

In the light of the present study findings, it can be concluded that:

Utilization of supportive psychotherapy with depressed patients under study showed great improvement of the patients' knowledge, reduction of depressive symptoms and enhancement of their QOL. Before program implementation there were highly statistically significant differences between the patients' residence, marital status, and working status and their total score of BDI and QOL. Meanwhile, after program implementation there were highly statistically significant differences between patients' age, working status and educational level and their total score of QOL.

RECOMMENDATIONS

Concept of supportive psychotherapy and quality of life should be integrated in nursing education curriculum to help nursing staff to guide patients with depression and their families on how to avoid and/or cope with depression to maintaining normal life style at highest possible level of quality of life.

Designing and implementing training programs for psychiatric nurses about utilization of supportive psychotherapy for depressed patients. Sustainability of supportive psychotherapy in outpatient clinics to decrease depressive symptoms, and enhance quality of life for patients with major depressive disorders.

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