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Original Article

The Relationship Between Perceived Social Support and Functional Status, Life Quality and Depression in Stroke Patients

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ABSTRACT

Objective: We aimed to examine the relationship of perceived social support with functional status, life quality and depression in stroke patients.

Methods: This study was carried out on 50 stroke patients who were diagnosed with stroke for the first time, who had a stroke for at least 6 months. Perceived social support with multidimensional perceived social support scale, functional status with Barthel index, life quality with stroke specific quality of life scale, and depression with Beck depression inventory were evaluated.

Results: The mean age of the patients (34 males, 16 females) was 56.70±10.78 years. The mean disease duration was 25.9±31.46 months. Mean multidimensional perceived social support scale score of the patients was 51.42±14. The multidimensional perceived social support scale scores were found significantly lower in stroke patients with fully/highly dependent than those of the other groups (p=0.02). There was no significant relationship between family support and functional status, but there was a significant correlation between functional status and friends support, private individual support (p=0.477, p=0.022, p=0.021, respectively). There was a significant positive correlation between life quality and all subscales of multidimensional perceived social support scale (p<0.05). Beck depression inventory score was significantly high in patients with low social support (p=0.001).

Conclusion: The perceived social support has a significant impact on functional status, quality of life and depression in stroke patients. The development of new intervention programs for perceived social support may significantly contribute to the rehabilitation treatment of stroke patients.

INTRODUCTION

Stroke has been the first place of terms of frequency and importance in the neurological diseases of adult life.[1] It is the first cause of disability and labor loss.[2] The aim of stroke rehabilitation is to maximize functional independence, to minimize the level of disability, to ensure successful reintegration into the home, family, and society, to regain a meaningful and satisfying life.[3] It is a known fact that problems after stroke cause serious deficits in physical, psychological, and social dimensions of life and cause a significant decrease in the life quality.[4] In recent years, factors related to the life quality after stroke and studies to improve the life quality has gained importance.[5,6] Stroke is a disease with a heavy social burden. One year after stroke, the rate of dependence on daily activities due to physical or cognitive deficits varies by 20-30%. Motor, cognitive, sensory, and emotional disorders after stroke prevent people's social participation by limiting their skills in some or all of basic, auxiliary daily living activities, edu-

cation, work, and leisure activities.[7] Social support is defined as the material and moral assistance provided to the stressed or troubled individuals by the people (wife, family, friends) around them.[8] Social support is an important factor to consider in the relationship between depression and functional disability. The theory of social support shows that social support has a direct and indirect impact on a variety of life aspects, including health indexes such as morbidity and mortality.[9]

Social relationships and social support are increasingly recognized as closely linked to individuals' overall health status, the progression of diseases, and the rehabilitation process. In individuals who have experienced a stroke, social support is considered to have a positive impact on patient care and treatment outcomes, particularly in terms of physical recovery and psychosocial well-being.[10]

After stroke, functional impairment, major depression, and social disintegration often adversely affect the life quality. Stroke patients who have physical or emotional impairment suffer from social disintegration and therefore they need intensive social support. Researches define potentially more effective patterns in providing rehabilitative care and suggest that an appropriate plan for rehabilitation of patients should aim to improve functional status, depressive disorder, and social participation.[11,12] The aim of this study was to investigate the relationship between perceived social support and functional status, life quality, and depression in stroke patients.

MATERIALS AND METHODS

This study was carried out on 50 stroke patients who were admitted to our outpatient. Stroke patients who were diagnosed with stroke for the first time, who had a stroke for at least 6 months, and who could communicate well enough to understand simple orders were included in the study. Patients with musculoskeletal and nervous system diseases (developmental hip dysplasia, severe osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, amputation, myasthenia gravis, Parkinson's disease, dementia, Alzheimer's disease) that could cause physical disability, communication, significant cognitive and emotional problems, and ataxia-dystonia-dyskinesia were excluded from the study.

The age, gender, marital status, occupational-educational status, disease duration, etiology of stroke (ischemic-hemorrhagic), body side affected by the stroke, additional concomitant diseases, and proximity to the caregiver were questioned in the patients. This study was approved by the University's Ethics in Research Committee and conducted according tothe Helsinki Declaration. The study procedure was told to the patients and before participating the study, written consent form was signed by all patients. Perceived social support with multidimensional perceived social support scale (MSPSS), functional status with Barthel index, life quality with stroke specific quality of life scale (SS-QOL), and depression with Beck depression inventory (BDI) were evaluated.

The multidimensional scale of perceived social support; the Turkish version of MSPSS was used in our study. The scale subjectively evaluates the adequacy of social support provided in three different areas and consists of 12 items. There are three sub-groups (family, friends and special person support) in the support areas of the scale, and each group consists of 4 items. The total score is obtained by adding the scores obtained from the subscales and the lowest score is 12, and the highest score is 84.[13,14]

Barthel index; Barthel index which is a dependable and validated index for use in Turkish patients were used to measure for changes in functional status. Barthel index evaluates performance in daily living activities. The total score ranges from 0 to 100. 0-20 points are fully dependent, 21-61 points are highly dependent, 62-90 are moderately dependent, 91-99 points are slightly dependent, and 100 are fully independent.[15,16]

Stroke specific quality of life scale; the SS-QOL consists of 49 items including 12 domains: Mobility, energy, upper limb function, work / productivity, mood, self-care, social roles, family role, seeing, language, thinking, and personality characteristics. The reliability and validity of the scale for the Turkish population were assessed by Hakverdioglu Yont.[17,18]

Beck depression inventory; the validity of the scale for the Turkish population were assessed by Hisli and the cut-off point of the scale was accepted as 17 points or higher. BDI consists of 21 questions and the score is 0-3 for each question. The highest score is 63. The high total score indicates the severity of depression.[19,20]

Statistical Analysis

The data obtained from the study were evaluated by using SPSS 21.0 software package. Kolmogorov-Smirnov test was used to determine whether the variables were normally distributed. T test / Mann Whitney U and One Way Anova / Kruskal Wallis tests were used to evaluate mean scores of the subscales of social support and the differences between the groups. Bonferroni Correction was used to determine which group was of significance. Pearson / Spearman correlation coefficients were calculated to evaluate the relationship between the outcomes in patients with stroke. P values less than 0.05 were considered statistically significant.

RESULTS

The mean age of the patients (34 males, 16 females) was 56.70±10.78 years. The mean disease duration was 25.92±31.46 months. The sociodemographic characteristics of the patients were shown in Table 1. Mean MSPSS score of the patients was 51.42±14. Among subgroups of social support, family support was 21.80±4.85, friend support was 15.22±5.95, and private individual support was 14.52±5.40. BDI score was 14.24±7.54, mean Barthel index score was 74.40±21.42 and mean SS-QOL scale was 3.07±0.60.

MSPSS score was higher in patients with disease duration longer than 1 year, but this difference was not statistically significant (t=-1.03, p=0.30). When education level increased in patients, the MSPSS score increased. MSPSS score in illiterate patients was 45.5±20.09, MSPSS score was 51.23±13.10 for the primary school graduates, MSPSS score was 57.21±11.01 for the secondary school and others graduates, but this difference is not statistically significant (f=1.59, p=0.21). The relationship between MSPSS scores and demographic characteristics is shown in Table 1. Patients with lower MSPSS scores than other groups had much worse functional status. The perceived social support was significantly lower in those with fully / highly dependent patients than other groups (f=3.90, p=0.02) (Table 2).

According to the Barthel index, 28 patients (56%) were moderately dependent, 10 patients (20%) were highly dependent, 6 patients (12%) were fully independent, 5 patients (10%) were mild dependent and 1 patient (2%) were fully dependent. According to cut-off score of BDI, 34% of the patients had depressive symptoms at the syndromic level, and 66% of the patients had lower scores than the cut-off score. There was a significant relationship between depressive status and perceived social support. The MSPSS score was significantly low in the group with scores above 17 points according to BDI (t=3.73, p=0.001). There was a significantly association between BDI scores and MSPSS scores (Table 3). There was a positive correlation between total MSPSS sore and the life quality (r=0.55, p=0.000). As the perceived social support increased, the life quality of the patients increased. Based on the analysis of perceived social support subscales data, there was a moderate positive correlation between the life quality and family support whereas the the life quality demonstrated a strong positive correlation with friend and private individual supports (r=0.42, p=0.002; r=0.51, p=0.000; r=0.52, p=0.000, respectively).

Table 1. Comparison of different socio-demographic characteristics with perceived social support levels in stroke patients

	Number (%)	Mean±SD	Perceived social support score, mean±SD	
Gender				
Female	16 (32)		46.25±16.41	T:-1.81
Male	34 (68)		53.85±12.44	P:0.07
Age (years)	56.7±10.78	51.42±14.12		R:-0.08
				P:0.56
Stroke etiology				
Hemorrhagic	13 (26)	50.62±12.65		T:-0.236
Ischemic	37 (74)	51.70±14.76		P:0.81
Marital status				
Married	36 (72)	52.00±13.60		T:-0.46
Single/ widowed	14 (28)	49.93±15.83		P:0.64
Affected side				
Right	15 (30)	53.93±13.18		T:0.82
Left	35 (70)	50.34±14.56		P:0.41
Additional disease				
No	7 (14)	52.86±16.24		T:0.28
Yes	43 (86)	51.19±13.95		P:0.80
Caregiver				
Caregiver	4 (8)	52±17.83		
Spouse	24 (48)	51.92±12.70		F:0.01
Spouse and child	12 (24)	52.17±15.84		P:0.95
Child	10 (20)	49.10±15.92		
Duration of the stroke				
≤1 year	29 (58)	49.66±14.26		T:-1.03
>1 year	21 (42)	53.86±13.90		P:0.30
Education status				
Illiterate	4 (8)	45.5±20.09		F:1.59
Primary school	30 (60)	51.23±13.10		P :021
Secondary school and others	14 (28)	57.21±11.01		

SD: Standart deviation.

Table 2. The relationship between perceived social support and functional status in stroke patients

	Fully/ highly dependent (N=11)	Moderately dependent (N=28)	Slightly/fully independent (N=11)	
Total perceived social support				
Mean±SD	41.55±13.50	53.79±13.17	55.27±13.69	F:3.90 P:0.02
Family support				
Mean±SD	20.27±5.64	21.93±4.65	23.00±4.56	KW:1.48 P:0.47
Friends support				
Mean±SD	10.91±5.35	16.36±5.65	16.64±5.67	KW:7.61 P:0.02
Special person support				
Mean±SD	10.55±4.48	15.64±5.25	15.64±5.12	KW:7.75 P:0.02

SD: Standart deviation; N: Number.

Table 3. The relationship between perceived social support and depression in stroke patients

	BDI<17 (N=33)	BDI≥17 (N=17)	
Total perceived social support	56.18±12.92	2.18±11.81	T:3.73,
Mean±SD			P:0.001
Family support	23.09±3.88	19.29±5.64	Z:-2.53
Mean±SD			P:0.011
Friends support	17.09±5.80	11.59±4.45	T:3.41
Mean±SD			P:0.001
Special person support	16.09±5.12	11.47±4.67	Z:-3.00
Mean±SD			P:0.003

SD: Standart deviation; N: Number; BDI: Beck depression inventory.

DISCUSSION

Life quality decreases significantly in patients with stroke due to functional deficiencies and medical, social, and psychological problems. Multidisciplinary comprehensive rehabilitation programs are needed to make easy patients' life and to improve their existing functions. The importance of the concept of social support has been demonstrated on individuals with chronic diseases and physical disabilities in studies in recent years. There are considerable evidence that social support positively affects mental and physical health.[21] It was stated that social support can prevent the occurrence of stress by changing the perception of events in stressful situations and by supporting the individual in situations where he is forced by affecting the ways of coping with stres.[22] In our study, there was relationship between perceived social support and the life quality, functional status, and depression in patients with stroke for the first time. As the perceived social support level increased, functional status and life quality level increased and depressive symptoms decreased in patients.

In the literature, there were no studies showing the relationship between age and social support in stroke patients. Molu et al.[23] showed that social support decreased, as patients get age in the psychiatric clinic. The decrease in the number of people around patients, due to the death of patient' peers due to aging, and retirement status of the patient is thought to be effective in this result. In our study, no significant relationship was found between perceived social support and age. In literature, there was no statistically significant difference between gender and social support in the study on social support in physically disabled individuals; however, level of social support was found to be higher in men than in women.[8] Dayapoglu et al.[12] showed that the level of social support in women was statistically lower than in men. Most of patients were male in our study. Perceived social support score was lower in women than in men, but no statistically significant difference was found. Dayapoglu et al.[12] found that a relationship between social support and education in stroke patients and social support score was found to be higher in highly educated people than other groups. In addition, they also found that married people had higher social support than other groups, but this was not statistically significant. In our study, it was found that perceived social support increased as education level increased and social perceived support was higher in married patients than un-

married patients, but this was not statistically significant. Procidano et al.[24] found that family support score was higher than social support sub-groups. Külcü et al.[25] reported that almost all inpatient stroke patients had family support. Furthermore, Bursa et al.[8] found that family support was higher in disabled individuals compared to subgroups of social support In our study, family support score was statistically significant compared to the sub-groups of social support. Most stroke patients require care because of functional losses and difficulties in self-expression. This situation may get the stroke patient dependent on another person. Since stroke patients who have a broader social network, friends, and relatives before stroke are dependent on home and bed after stroke, their social networks gradually decrease over time, and patients become more lonely. We think that the high family support score in our study is related to above reasons.

In our study, a significant relationship was found between perceived social support and functional status of the patients. Patients with lower perceived social support scores had worse functional status than other groups. In the subgroups of patients who are fully / advanced dependent, the level of subgroups of friend and private individual support was significantly lower than the other groups. The family support rate was similar across all groups, unaffected by the disease's functional status. The mean family support is statistically significantly lower in individuals with higher Beck Depression Index scores. This highlights the significance of family support. However, there was no significant relationship between family support and functional status compared to other groups. Glass et al.[26] found that patients with low social support were unable to maintain functional recovery and decreased functional status over time.

Morris et al.[27] reported that the amount of post-stroke social contact may reduce the risk of depression in later times. In a prospective study by Volz et al.[28] it is stated that the beneficial effects of perceived social support had a protective effect in terms of not developing depression after stroke. Lewin et al.[29] stated that taking into account self-efficacy and perceived social support in rehabilitation treatment may help prevent depression after stroke. In our study, a significant relationship was found between depression and sub-groups of social support (family-friend-special person). The level of social support was significantly lower in the patient group with high depressive symptoms than groups. These findings were consistent with the literature.

Stroke is a disease that causes severe loss of physical activity in the person and has a significant impact on health-related life quality.[5] Huang et al.[30] showed that social support fully mediated the prediction of the life quality and they recommended that social support be included for effective rehabilitation treatment.[30] When the relationship between life quality and perceive social support was investigated, we found that as the perceived social support of the patients increased, the life quality also increased in our study. We found a moderately positive relationship between family support and life quality, and a strong positive relationship between life quality and support of friends and private individuals. Strong social support given to post-stroke patients can significantly reduce the negative impact of stroke on patients' life quality.[31]

We recognize that the present study has some limitations. At first, The sample size in our study may be to small to make a definitive decision. Further studies with larger patient populations are needed to confirm our results. Second, the number of male patients was higher than female patients in our study. This may create certain restrictions in evaluating the relationship between perceived social support and gender.

In conclusions, results of this study showed that a relationship was between perceived social support and functional status, life quality, and depression in stroke patients. Although the results of the study were predictable, it may be useful to consider the importance of the concept of perceived social support in stroke rehabilitation and to develop strategies aimed at enhancing existing social support in the treatment management of stroke patients.

Ethics Committee Approval

The study was approved by the Recep Tayyip Erdoğan University Hospital Ethics Committee (Date: 16.03.2018, Decision No: 2018/56).

Informed Consent

Retrospective study.

Peer-review

Externally peer-reviewed.

Authorship Contributions

Concept: E.O., G.D.; Design: E.O., G.D.; Supervision: E.O., G.D., M.S.B.; Fundings: E.O., M.Y., G.D.; Materials: E.O., G.D., M.Y.; Data collection &/or processing: E.O., G.D., M.Y., M.S.B.; Analysis and/or interpretation: E.O., G.D.; Literature search: E.O.,G.D., M.Y.; Writing: E.O., G.D.; Critical review: E.O., G.D., M.Y., M.S.B.

Conflict of Interest

The authors declare that they have no conflict of interest.

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REFERENCES

1. Murray CJ, Lopez AD. Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. Lancet 1997;349:1436-42. [CrossRef]
2. Kumral E. Serebrovasküler hastalıklar. 3rd ed. Ankara: Güneş Kitabevi; 2009. p. 37-50.
3. Brandstater ME. Stroke rehabilitation. In: Delisa JA, editor. DeLisa's physical medicine and rehabilitation: Principles and practice. 5th ed. Philadelphia: Lippincott Williams & Wilkins; 2010. p. 551-71.
4. Demir Yazıcı Ş. İnmeli hastalarda yaşam kalitesini etkileyen faktörler [medical specialization thesis]. Edirne: Trakya Üniversitesi; 2010. [In Turkish]

5. Senocak O, El O, Söylev G, Avcilar S, Peker O. Factors affecting quality of life following stroke. J Neurol Sci Turk 2008;25:164-70.
6. Karaahmet OZ, Gurcay E, Avluk OC, Umay EK, Gundogdu I, Ecerkale O, et al. Poststroke depression: Risk factors and potential effects on functional recovery. Int J Rehabil Res 2017;40:71-5. [CrossRef]
7. Kristensen HK, Borg T, Hounsgaard L. Aspects affecting occupational therapists' reasoning when implementing research-based evidence in stroke rehabilitation. Scand J Occup Ther 2012;19:118-31. [CrossRef]
8. Dane Bursa. Fiziksel engelli bireylerde depresyon ve çok boyutlu algılanan sosyal destek düzeyi [master's thesis]. Konya: Selçuk Üniversitesi; 2010. [In Turkish]
9. Horowitz A, Reinhardt JP, Boerner K, Travis LA. The influence of health, social support quality and rehabilitation on depression among disabled elders. Aging Ment Health 2003;7:342-50. [CrossRef]
10. Berkman LF, Glass T, Brissette I, Seeman TE. From social integration to health: Durkheim in the new millennium. Soc Sci Med 2000;51:843-57. [CrossRef]
11. Tsouna-Hadjis E, Vemmos KN, Zakopoulos N, Stamatelopoulos S. First-stroke recovery process: The role of family social support. Arch Phys Med Rehabil 2000;81:881-7. [CrossRef]
12. Dayapoğlu N, Tan M. The perceived social support of stroke patients from their families. J Atatürk Univ High Sch Nurs 2009;12:41-8.
13. Zimet GD, Dahlem NW, Zimet SG, Farley GK. The multidimensional scale of perceived social support. J Pers Assess 1988;52:30-41. [CrossRef]
14. Eker D, Arkar H, Yaldız H. Çok boyutlu algılanan sosyal destek ölçeğinin gözden geçirilmiş formunun faktör yapısı, geçerlik ve güvenirliği. Turk Psikiyatri Derg 2001;12:17-25. [Article in Turkish]
15. Wade DT, Collin C. The Barthel ADL Index: A standard measure of physical disability? Int Disabil Stud. 1988;10:64-7. [CrossRef]
16. Küçükdeveci AA, Yavuzer G, Tennant A, Süldür N, Sonel B, Arasil T. Adaptation of the modified Barthel Index for use in physical medicine and rehabilitation in Turkey. Scand J Rehabil Med 2000;32:87-92.
17. Williams LS, Weinberger M, Harris LE, Clark DO, Biller J. Development of a stroke-specific quality of life scale. Stroke 1999;30:1362-9. [CrossRef]
18. Hakverdioğlu Yönt G. İnme'ye özgü yaşam kalitesi ölçeğinin Türk toplumu için geçerlik ve güvenirliğinin incelenmesi [dissertation]. İzmir: Ege Üniversitesi; 2009. [In Turkish]
19. Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. Arch Gen Psychiatry 1961;4:561-71. [CrossRef]
20. Hisli N. Beck depresyon envanterinin üniversite öğrencileri için geçerliği, güvenirliği. Psikol Derg 1989;7:3-13. [Article in Turkish]
21. Holt-Lunstad J, Uchino B. Social support and health. In: Glanz K, Rimer BK, Viswanath K, editors. Health behavior: Theory, research, and practice. San Francisco (CA): Jossey-Bass; 2015. p. 183-204.
22. Sorias O. Hasta ve sağlıklı öğrencilerde yaşam stresi, sosyal destek ve ruhsal hastalık ilişkisinin incelenmesi. Seminer Psikol Derg 1992;9:33-49. [Article in Turkish]
23. Günay Molu N. Selçuk Üniversitesi Tıp Fakültesi Psikiyatri Servisinde duygulanım bozukluğu tanısı ile yatan hastaların yakınlarının sosyal destek ve stresle baş etme düzeylerinin belirlenmesi [master's thesis]. Konya: Selçuk Üniversitesi; 2008. Turkish. [In Turkish]
24. Procidano ME, Heller K. Measures of perceived social support from friends and from family: Three validation studies. Am J Community Psychol 1983;11:1-24. [CrossRef]
25. Geler Külcü D, Kuran B, Karahan AY, Özgirgin N, Başaran S, Yalıman A, et al. Demographic and clinical characteristics of inpatient stroke patients in Turkey. Turk J Phys Med Rehabil 2022;68:9-18. [CrossRef]
26. Glass TA, Matchar DB, Belyea M, Feussner JR. Impact of social support on outcome in first stroke. Stroke 1993;24:64-70. [CrossRef]
27. Morris PL, Robinson RG, Raphael B, Bishop D. The relationship between the perception of social support and post-stroke depression in hospitalized patients. Psychiatry 1991;54:306-16. [CrossRef]
28. Volz M, Möbus J, Letsch C, Werheid K. The influence of early depressive symptoms, social support and decreasing self-efficacy on depression 6 months post-stroke. J Affect Disord 2016;206:252-5. [CrossRef]
29. Lewin A, Jöbges M, Werheid K. The influence of self-efficacy, pre-stroke depression and perceived social support on self-reported depressive symptoms during stroke rehabilitation. Neuropsychol Rehabil 2013;23:546-62. [CrossRef]
30. Huang CY, Hsu MC, Hsu SP, Cheng PC, Lin SF, Chuang CH. Mediating roles of social support on poststroke depression and quality of life in patients with ischemic stroke. J Clin Nurs 2010;19:2752-62. [CrossRef]
31. Dąbrowska-Bender M, Milewska M, Gołąbek A, Duda-Zalewska A, Staniszewska A. The impact of ischemic cerebral stroke on the quality of life of patients based on clinical, social, and psychoemotional factors. J Stroke Cerebrovasc Dis 2017;26:101-7. [CrossRef]

İnmeli Hastalarda Algılanan Sosyal Destek ile Fonksiyonel Durum, Yaşam Kalitesi ve Depresyon Arasındaki İlişki

Amaç: İnme hastalarında algılanan sosyal desteğin fonksiyonel durum, yaşam kalitesi ve depresyonla ilişkisini incelemeyi amaçladık.

Gereç ve Yöntem: Bu çalışma, ilk kez inme tanısı almış, en az 6 aydır inme tanısı olan 50 inmeli hastada gerçekleştirildi. Algılanan sosyal destek çok boyutlu algılanan sosyal destek ölçeği ile, fonksiyonel durum Barthel indeksi ile, yaşam kalitesi inmeye özgü yaşam kalitesi ölçeği ile ve depresyon Beck depresyon envanteri ile değerlendirildi.

Bulgular: Hastaların (34 erkek, 16 kadın) yaş ortalaması 56.70±10.78 yıl idi. Hastalık süresi ortalaması 25.9±31.46 aydı. Hastaların çok boyutlu algılanan sosyal destek ölçeği puanı ortalaması 51.42±14 idi. Tam/yüksek derecede bağımlı inme hastalarında çok boyutlu algılanan sosyal destek ölçeği puanları diğer gruplara göre anlamlı derecede düşük bulundu (p=0.02). Aile desteği ile fonksiyonel durum arasında anlamlı bir ilişki bulunmazken, arkadaş desteği, özel bireysel destek ile fonksiyonel durum arasında anlamlı bir korelasyon vardı (sırasıyla p=0.477, p=0.022, p=0.021). Yaşam kalitesi ile çok boyutlu algılanan sosyal destek ölçeğinin tüm alt ölçekleri arasında anlamlı ve pozitif bir korelasyon vardı (p<0.05). Beck depresyon ölçeği puanı, düşük sosyal desteği olan hastalarda anlamlı derecede yüksekti (p=0.001).

Sonuç: Algılanan sosyal destek, felçli hastalarda fonksiyonel durum, yaşam kalitesi ve depresyon üzerinde önemli bir etkiye sahiptir. Algılanan sosyal destek için yeni müdahale programlarının geliştirilmesi, inmeli hastaların rehabilitasyon tedavisine önemli ölçüde katkıda bulunabilir.

Anahtar Sözcükler: Algılanan sosyal destek; depresyon; fonksiyonel durum; inme; yaşam kalitesi.