The Relationship between Social Support and Recovery Levels among Patients with Psychatric Disorders

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.**ABSTRACT**

Background: Social support is an important element in the recovery of clients with psychiatric disorders. There is a lack of studies investigating the relative impact of factors related to social support. Disentangling these could enhance recovery for psychiatric patients. **Aim:** This study aimed to explore the relation between social support and recovery among patients with psychiatric disorders. **Subjects and Method:** A descriptive correlational research design utilized in this study. The study subjects comprised sample of 162 psychiatric patients from outpatient clinic of Port Said Psychiatric Health and Addiction Treatment, Egypt. Two tools were utilized to collect the necessary data, Multidimensional Scale of Perceived Social Support and Recovery Assessment Scale, in addition to a personal and clinical data sheet. **Results**: nearly two thirds of the studied psychiatric patients got low perceived total social support. Also nearly three quadrants of the studied psychiatric patients had low level of psychological recovery. **Conclusion and Recommendations:** It can be concluded from the present study that there was a positive statistically significant correlation between perceived social support and recovery for psychiatric patients. Therefore, enhancing social support while caring for psychiatric patients is recommended to regain recovery. Further studies are needed to improve recovery for psychiatric patients.

Keywords: Patients with Psychiatric patient**,** Recovery and Social support.

INTRODUCTION

Mental disorders affect roughly one-third of the world's population (29.2%), resulting in significant worldwide burden, disability, loss of productivity, morbidity, and mortality. (Vaingankar et al., 2020). Psychiatric disorders have fewer social contacts, often of lower perceived quality than individuals without such diseases. People with mental illnesses have poor social outcomes because they are more vulnerable to social dysfunction, weak social networks, and interpersonal issues. These usually lead to a lack of social support, which has been found to have a negative influence on symptom control, hospitalization period, and death (Beckers, Maassen , Koekkoek , Tiemens & Hutschemaekers, 2022).

Social support may be given via any person who has either blood relation or non-blood relation with the affected person and most patients expect social support from their families than from others. Social support is classified into "structural components" like social networks and "functional components" like perceived social support, which is divided into instrumental (or concrete) and emotional (or intangible) support. When measuring social support, it's important to distinguish between received and perceived support (Roth et al., 2021).

Received social support aims to objectively sum up the social support that a person receives (usually through observations), whereas perceived social support evaluates the type and/or amount of social support that a person believes he or she has received. Social support has been highlighted as a crucial healing tool and a critical source of psychological well-being (El-Monshed & Amr, 2020).

Recovery is rated the top possible result for mental patients, suggesting a long period without any psychiatric symptoms and adequate occupational and social functioning. Recovery has many components, including clinical, social, and personal dimensions, but from the perspective of a person with a mental illness, it includes regaining and maintaining hope, recognizing one's skills and limitations, and participating in an active, purposeful life (Hamza, Berma & El-said, 2022). While each patient sets their own recovery goals, the most common are clinical recovery (remission of mental illness), functional recovery (meaningful participation in society), and personal/social recovery

(ability to work or study, live independently, engage in meaningful social activities, and trying to reclaim one's identity) (Keet et al., 2019).

Social support is an important treatment factor in the recovery of people with psychiatric disorders. Individuals with psychiatric disorders who have access to social support are more likely to seek treatment for their mental health issues when they are most in need (Harfush& Gemeay, 2018). Patients with more social support are less likely to be admitted to a psychiatric institution, whether voluntary or involuntary (Van Veen et al., 2019). Social support is one of the proposed interventions which turned into used to reduce the impact of an event specified in causing mental illness. During the COVID-19 crisis, the absence of social support for those with serious mental illness has only become worsened (Wildman, MacManus, Kuipers &Onwumere, 2021).

World Health Organization emphasizes the importance of strengthening social support for preventing the impact of mental illness and minimizing barriers to accessing mental health services. Patients with poor social support had bad outcomes in terms of adherence, response, recovery, and functionality. However, patients with strong social support have a better quality of life, capacity to cope with stress, self-esteem, and efficacy, help-seeking behavior, and medication adherence; have less chance of relapse, and suicide attempts (Cam & Yalcıner, 2018). Improvements in the accessibility of seeking and treatment compliance, as well as increased perceived social support, have been critical in terms of clinical recovery in patients with mental illnesses (Vaingankar et al., 2020). In psychosis, the nurse plays an active role in improving sociability. Nurses can help patients and their families know how to manage medical disorders, the necessity of medication adherence, follow-up plans, and strengthen social support linkages between patients and their families. As a result, social media activation is a key aspect of nursing interventions, and it's considered an occasional price strategy for market recovery (Bjo̊rlykhaug, Karlsson, Hesook & Kleppe, 2021).

Significance of the study

Social support plays a vital role in day to-day activities, treatment progress, relapse, and medication adherence of mentally ill patients. Despite its critical importance, there is a paucity of evidence on the effect of social support on the treatment outcome of mentally ill patients in treatment facilities. Patients with upright social support show

better recovery and functionality. Recovery can be a dynamic process marked by progress toward conditions of hope and meaning. Participation in meaningful social life may be a primary goal for many people in recovery, so research on recovery relationships, social support, and social activities is essential (Bjŏrlykhaug et al., 2021).

AIM OF THE STUDY

This study aimed to explore the relation between social support andrecovery among patients with psychiatric disorders.

Research objectives

1. Assess levels of social support among patients with psychiatric disorders.
2. Measure levels of recovery among patients with psychiatric disorders.
3. Find out the relation between social support and recovery among patients with psychiatric disorders.

SUBJECTS AND METHOD

Study design

A descriptive correlational research design was utilized in this study.

Study setting

The present study was carried out in outpatient clinic of Port Said Psychiatric Health and Addiction Treatment affiliated to the general secretariat Hospitals, Egypt. It is joined to General Secretariat of Mental Health and Addiction Treatment (GSMHAT), Ministry of Health.

The hospital capacity is 140 beds; delivers care to psychiatric patients and substance abusers. It serves all the catchment areas in Port Said and three neighboring governorates (El-Ismailia, Sina, and El Suez). The hospital comprises three inpatient psychiatric departments, one male department for addiction treatment, and Furthermore, two clinics, one outpatient clinic for children. Furthermore; psychiatric outpatient clinics, which are accessible from 10 a.m. to 2 p.m. 6 days per week. It involves three rooms specialized for treatment and continuation of patients with mental disorders.

Study subjects

The study subjects were a sample of psychiatric outpatients, from both sexes, diagnosed with the following psychiatric disorders; schizophrenia, mood disorders and schizoaffective disorders, and able to communicate effectively.

Inclusion criteria: a sample of patients (of either gender) having psychiatric diagnoses, such as mood disorders, schizoaffective disorders, and schizophrenia. They must be eager to take part in the research and have good communication skills.

Sample size:

The sample size will be determined by using the following equation:

$$\textbf{Sample Size (n)} = \frac{Z^2}{\Delta^2} P(100 - P) \text{ (Dobson, 1984)}$$

Where:

P: The expected prevalence of psychiatric disorders in Egyptis=24.9 % (Kamelet al., 2020).

Z: A percentile of standard normal distribution determined by 95% confidence level = 1.96.

Δ : The width of the confidence interval = 7.

$$\textbf{Sample Size (n)} = \frac{1.96^2}{[7]} \quad 24.9 \times (100 - 24.9) = 147 \text{ patients}$$

The calculated sample size will be 147 patients. Due to the design effects (1.25), expected non-participating rate (10%), the final sample size will be 162 patients.

Tools of data collection

The data were collected through utilizing the following tools:

Tool I: Multidimensional Scale of Perceived Social Support (MSPSS) Classified into Two parts

Tool I Part I: Personal and Clinical Data Sheet

This structured sheet will be developed by the researcher in an Arabic language. The sheet elicits personal characteristics as age, sex, marital status, level of education, occupational status, and income. It also includes questions that cover data related to diagnosis, duration of illness, number of previous psychiatric hospitalization and date of last hospitalization

Tool I Part II: Multidimensional Scale of Perceived Social Support (MSPSS)

A Multidimensional Scale of Perceived Social Support (MSPSS) was developed by Zimet, Dahlem, Zimet, & Farley (1988), in an English language and translated into Arabic by Abou Hashem (2010). It is a 12-items instrument designed to assess perceptions of social support about three specific sources including family, friends, and significant others. Social support about family members (items3, 4, 8, and 11), social support about friends (items6, 7, 9, and 12), social support about significant others (items1, 2, 5, and 10).

Scoring System

The scale is rated on a five point likert scale ranging from 1= "strongly disagree" to5= "strongly agree." Scores for the total items were summed to determine the level of perceived social support among psychiatric patients. Higher score indicates higher social support. A critical value 60% is indicated as the optimal cut-off point for assessing perceived social support. Studies demonstrate levels of social support that nearly two thirds (66%) of the studied psychiatric patients got low perceived total social support, while 34% of them got high perceived total social support. The patient's perceived social support was considered high if the percentage was 60% or more and low if less than 60%.(Abou Hashem , 2010).

Validity and Reliability of the Scale

The Arabic version of MSPSS revealed reliability and notable internal consistency with Cronbach's Alpha, the internal consistencies of three specific sources including family, friends, and significant other were (α =.85). Validity was done by a board of specialists who decided that the scale was valid (Abou Hashem, 2010)

TOOL II: Recovery Assessment Scale (RAS)

Recovery Assessment Scale was developed by Giffort, Schmook, Woody, Vollendorf, & Gervain, (1995), in an English language and translated into Arabic language by Al Sheakh-Ali (2013). The RAS consisted of 40 statements that covered 5 dimensions which designed to measure recovery level among psychiatric patients. The five dimensions of recovery including purpose and success (6 items), level of dependence on self and others (10 items), veracity and hope (11 items), aptitude to seek help (7 items), and safety and knowledge (6 items).

Scoring System

The study subjects' responses for RAS dimensions will be rated on a 5-point Likert scale format ranging from strongly agree (5) to strongly disagree (1). Items were scored 5, 4, 3, 2, and 1 for the responses "strongly agree," "agree," "uncertain," "disagree," and "strongly disagree" respectively. The scoring will be reversed in the negative statements (items 16, 32, and 35). Each dimension will be calculated by summing the scores for the relevant items and the overall will be distributed by the number of items, providing a mean score of each dimension. The scores will be transformed into a percentage score.

The score of recovery will be considered by summing scores of all dimensions and the full score will be distributed by the total of all items, providing a mean score. Recovery level is considered low if the percent score was less than 60%, and high if equal or more. (Giffor et al., 1995).

Validity and Reliability of the Scale

The Arabic version of RAS showed a tremendous significant reliability plus acceptable validity, with Cronbach's Alpha $\alpha = 0.94$. Validity was done by a jury of specialists who agreed that the scale is valid.

Pilot study

Before entering the actual study, a pilot study carried out on 10 % of the study sample (16 patients), who were selected randomly. It had done to ascertain the relevance, clarity and applicability of the used tools and to estimate the time needed to fill in the

data collection tools. The patients who included in the pilot study weren't involved in the main study sample to assure the reliability of the attained results. According to pilot study results, necessary modifications had been done.

Field Work

The data collection process will be conducted using face to face interview technique that will be done on an individual basis, and this will be done on a private area in the outpatient clinic to ensure privacy and confidentiality of the collected data.

Administrative design

Before starting any step in the study, an official letter from the Dean of the Faculty of Nursing, Port Said University had been sent to the Director of the above mentioned setting requesting his permission and cooperation to conduct the present research after clarifying the aim of the study.

Ethical considerations

The study protocol has been approved by the Research Ethical Committee of the Faculty of Nursing, Port Said University, **(code NUR3/7/2022)**. The study protocol had been approved by the Ethical Committee of The General Secretariat of Mental Health and Addiction Treatment (GSMHAT), Ministry of Health and Population, An informed consent obtained from the studied patients after explaining the aim of study, Confidentiality of the collected data confirmed that it used only for the purpose of scientific research and anonymity is guaranteed, voluntary participation of study subjects has confirmed as they had informed that they have the right to withdraw from study at any time.

Statistical design

Upon completion of the data collection, the collected data had coded, tabulated, and statistically analyzed using SPSS version 20.0. Quantitative data had expressed using the means and standard deviations, and qualitative data had expressed using numbers and percentages. Analysis of variance test had used to compare between more than two groups of normally distributed variables. The statistical significance value was considered at P-value ≤ 0.05.

RESULTS

Table (1) shows that slightly more than one third (34.6%) of the studied psychiatric patients are aged between 41 – 50 years old with mean 43.4±1.01 and 52.5% of them are females. Concerning to social status, only 11.1% of the studied psychiatric patients is married and 17.3% of them had moderate education. In relation to the job status, this table reveals that more than half (58.6%) of the studied psychiatric patients didn't work

Table (2) reveals that 35.2% of them had psychiatric disorder from 1 to less than 5 years with mean 8.3±7.8. Also, more than two thirds (68.5%) of the studied psychiatric patients aren't admitted to psychiatric hospital and 33.3% of them had twice admission to psychiatric hospitals. Regarding to the discharge state from psychiatric hospitals, it is obvious from this table that, the majority (94.1%) of the studied psychiatric patients discharged from hospital due to their improvement and 91.4% of them follow up at outpatients by their will.

Figure (1) reveals the distribution of the total sources of social support that perceived by psychiatric patients, it is obvious that most (82.1%) of them got high perceived social support from their family members and 67.9% of them got high perceived social support from significant others, also 19% of them got high perceived social support from their friends. While 17.9%, 81% and 32.1% of the studied psychiatric patients got low social support from their family members, friends and significant others respectively

Figure (2) demonstrates that nearly two thirds (66%) of the studied psychiatric patients got low perceived total social support, while 34% of them got high perceived total social support.

Figure (3) reveals the total psychological recovery, nearly three quarters (25.9%) of the studied psychiatric patients had high level of recovery, while 74.1% of them had low level of recovery.

Table (3) shows that there was statistically significant relation between social status of the studied psychiatric patients and their total perceived social support ($p< 0.01$). Also there was statistically significant relation between job status of the studied psychiatric patients and their total perceived social support ($p< 0.01$).

Table (4) demonstrates the relation between clinical characteristics of the studied psychiatric patients and their total perceived social support, it shows that there was statistically significant relation between diagnosis of the studied psychiatric patients and their total perceived social support ($p< 0.01$). Also there was statistically significant relation between previous hospitalization of the studied psychiatric patients and their total perceived social support ($p=.016$).

Table (5) demonstrates relation between personal characteristics of the studied psychiatric patients and their total recovery, it is obvious that there was statistically significant relation between social status, educational level, job status, family income of the studied psychiatric patients and their total recovery ($p= .027$, $p= .041$, $p= .000$ and $p= .005$) respectively.

Table (6) displays that; there was statistically significant relation between clinical characteristics (diagnosis and previous hospitalization) of the studied psychiatric patients and their total recovery ($p< 0.01$).

Table (7) reveals that there was highly statistically significant positive correlation between total psychological recovery of the studied psychiatric patients and their total perceived social support ($p< 0.01$).

Table (1): Number and percentage distribution of the studied psychiatric patients' according to their personal characteristics (n=162).

Personal characteristics	**N**	**%**
Gender		
Male	77	47.5
Female	85	52.5
Age / years		
20 - < 30	15	9.3
30 - < 40	52	32.1
40 - < 50	56	34.6
50- < 60	29	17.9
> 60	10	6.1
Mean± SD	1.01±43.4	
Residence		
Urban	131	80.9
Rural	31	19.1
Social Status:		
Single	102	62.9
Married	18	11.1
Divorced/ Widowed	42	25.9
Educational levels		
Not read & write	95	58.6
Read and write	15	9.3
Basic education	2	1.2
Moderate education	28	17.3
High education	22	13.6
Working Status		
Working	67	41.4
Not working	95	58.6
Type of work (n=67):		
Employee	44	65.7
Professional	23	34.3

Table (2): Distribution of the studied psychiatric patients according to their clinical characteristics (n=162)

Clinical characteristics	N	%
Diagnosis		
Schizophrenia	73	45.1
Schizoaffective disorders	36	22.2
Depression	40	24.7
Mania	13	8.0
Onset of psychiatric disorders/ years		
1 < 5	57	35.2
5 < 10	53	32.7
10 < 15	31	19.1
15 < 20	6	3.7
≥ 20	15	9.3
Mean ±SD	**8.3±7.8**	
Previous hospitalization		
Yes	51	31.5
No	111	68.5
Frequency of admission to hospitals (n=51)		
Once	8	15.8
Twice	17	33.3
Three times	13	25.5
Four times and more	13	25.4
Date of last admission to hospitals/ years (n=51)		
< 1	10	19.6
1 < 5	28	54.9
5 < 10	10	19.6
10 – 15	3	5.9
Mean ±SD	**1.3±0.7**	
Discharge state (n=51)		
Family request	2	3.9
Improvement	48	94.1
Escape	1	2.0
Follow up at outpatients		
By patient's will	148	91.4
Against patient's will	14	8.6

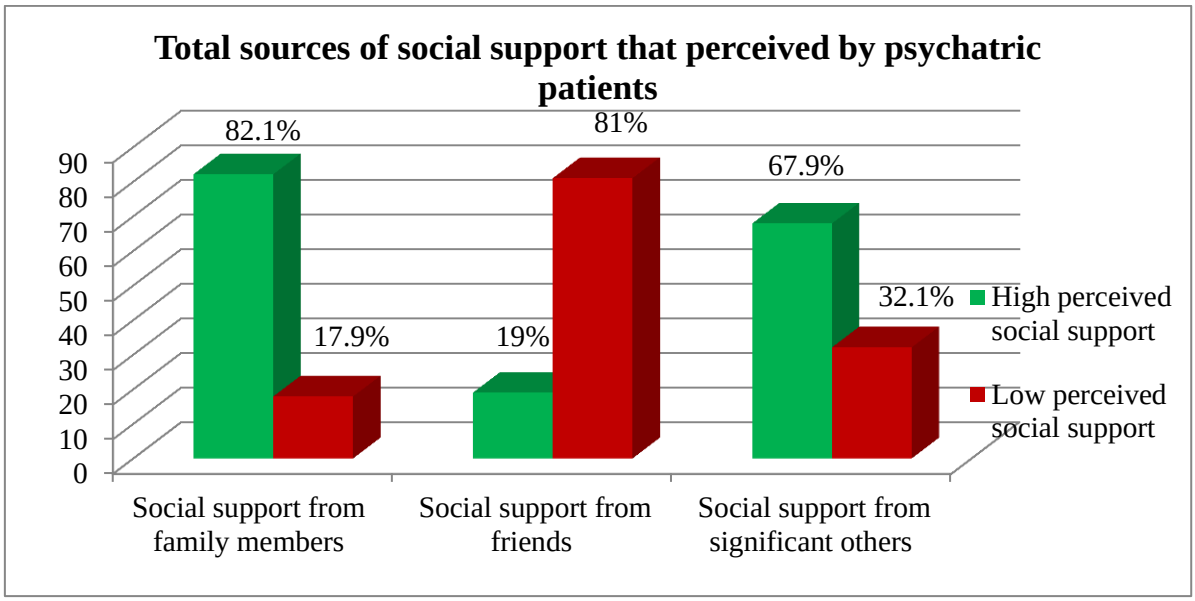

Figure (1): Distribution of the total sources of social support that perceived by psychiatric patients (n= 162)

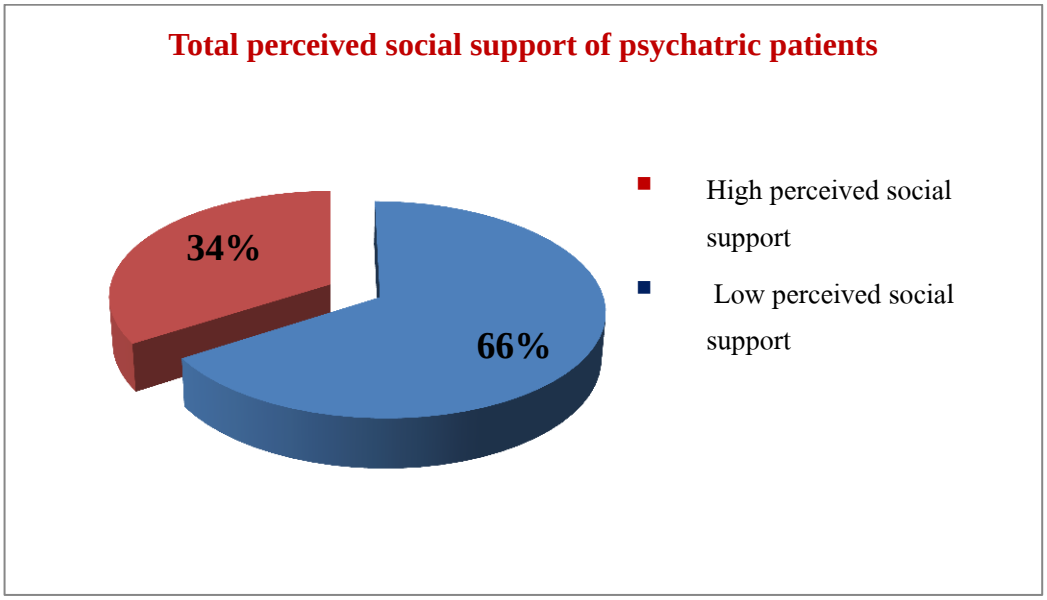

Figure (2): Distribution of the studied psychiatric patients according to their total perceived social support (n= 162)

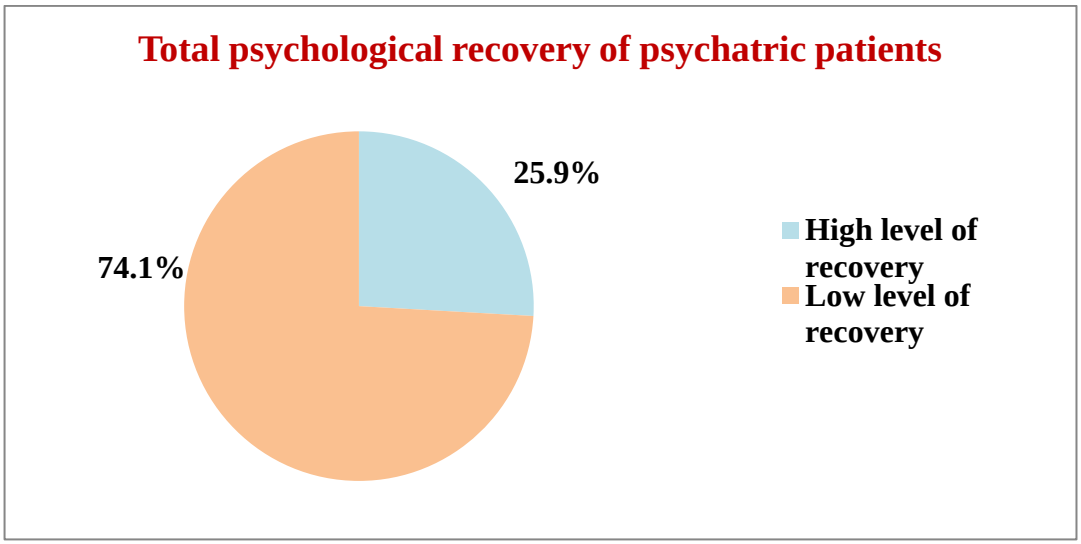

Figure (3): Distribution of the studied psychiatric patients according to their total psychological recovery (n= 162)

Table (3): Relation between personal characteristics of the studied psychiatric patients and their total perceived social support (n=162)

Personal' characteristics	Total perceived social support				X^2	Sig
	Low support		High support			
	N	%	N	%		
Age (years):						
20 – < 30	2	13.3	13	86.7	4.35	.360
31 –< 40	21	40.4	31	59.6		
41 - < 50	18	32.1	38	67.9		
51 – < 60	8	27.6	21	72.4		
> 60	3	30.0	7	70.0		
Gender:						
Male	20	26.0	57	74.0	2.52	.112
Female	32	37.6	53	62.4		
Social Status:						
Single	17	40.5	25	59.5	16.77	**.001**
Married	21	21.6	76	78.4		
Divorced/ Widowed	14	60.9	9	39.1		
Educational level:						
Not read & write	13	46.4	15	53.6	4.69	.454
Read and write	4	26.7	11	73.3		
Basic education	0	0.0	2	100.0		
Moderate education	30	31.6	65	68.4		
High education	5	22.7	17	72.3		
Working Status:						
Working	8	11.9	59	88.1	21.3	**.000**
Not working	44	46.3	51	53.7		
Family income						
Enough	3	42.9	4	57.1	3.15	.207
Somewhat enough	11	22.4	38	77.6		
Not enough	38	35.8	68	64.2		

X^2- Chi square test Significant level (p< 0.05) Highly significant level (p< 0.01)

Table (4): Relation between clinical characteristics of the studied psychiatric patients and their total perceived social support (n=162)

Clinical characteristics	Total perceived social support				X2	Sig
	Low support		High support			
	N	%	N	%		
Diagnosis: Schizophrenia Schizoaffective disorders Depression Mood disorders	12 11 24 5	16.4 30.6 60.0 38.5	61 25 16 8	83.6 69.4 40.0 61.5	23.84	**.001**
Onset of psychiatric disorders/ years: 1 < 5 5 < 10 10 < 15 15 < 20 ≥ 20	17 15 14 0 6	29.8 28.3 45.2 0.0 40.0	40 38 17 6 9	70.2 71.7 54.8 100.0 60.0	6.18	.186
Previous hospitalization Yes No	23 29	45.1 26.1	28 82	54.9 73.9	5.77	**.016**

x2- Chi square test Significant level (p< 0.05) Highly significant level (p< 0.01

Table (5): Relation between personal characteristics of the studied psychiatric patients and

Personal' characteristics	Total recovery				X^2	Sig
	Low recovery		High recovery			
	N	%	N	%		
Age (years):						
20 – 30	2	13.3	13	86.7		
31 – 40	16	30.8	36	69.2		
41 - 50	38	67.9	18	32.1	5.46	.243
51 – 60	24	82.8	5	17.2		
> 60	1	10.0	9	90.0		
Gender:						
Male	44	51.8	41	48.2	.120	.730
Female	23	27.1	62	72.9		
Social Status:						
Single	16	38.1	26	61.9	9.15	**.027**
Married	17	17.5	80	82.5		
Divorced/ widowed	9	39.1	14	60.9		
Educational level:						
Not read & write	12	42.9	16	57.1		
Read and write	3	20.0	12	80.0	11.56	**.041**
Basic education	0	0.0	2	100.0		
Moderate education	26	27.4	69	72.6		
High education	1	4.5	21	95.5		
Job Status						
Work	4	6.0	63	94.0	23.65	**.000**
Not work	38	40.0	57	60.0		
Family income						
Enough	0	0.0	7	100.0	10.79	**.005**
Somewhat enough	6	12.2	43	87.8		
Not enough	36	34.0	70	66.0		
Residence						
Urban	64	48.9	67	41.9	22.34	**.000**
Rural	28	90.0	3	10.0		

X^2- Chi square test Significant level ($p< 0.05$) Highly significant level ($p< 0.01$)

Table (6): Relation between clinical characteristics of the studied psychiatric patients and their total recovery (n=162)

Clinical characteristics	Total recovery				X^2	Sig
	Low recovery		High recovery			
	N	%	N	%		
Diagnosis:						
Schizophrenia	6	8.2	67	91.8	33.32	**.000**
Schizoaffective disorders	10	27.8	26	72.2		
Depression	21	52.5	19	47.5		
Mood disorders	5	38.5	8	61.5		
Onset of psychiatric disorders/ years:						
1 < 5	13	22.8	44	77.2	1.15	.887
5 < 10	14	26.4	39	73.6		
10 < 15	9	29.0	22	71.0		
15 < 20	1	16.7	5	83.3		
≥ 20	5	33.3	10	66.7		
Previous hospitalization						
Yes	21	41.2	30	58.8	9.01	**.003**
No	21	18.9	90	81.1		

X^2- Chi square test Significant level (p< 0.05) Highly significant level (p< 0.01)

Table (7): Correlations between total perceived social support of psychiatric patients and their total psychological patient levels of recovery

Items	Total perceived social support	
	R	p-value
Total psychological patient levels of recovery	.647**	.000

r- pearson correlation coefficient , Significant level (p< 0.05)
Highly significant level (p< 0.01)

DISCUSSION

Social support has been described as the available aid in the physical& psychological needs and the encouragement provided by individuals who make up the contact network, that is, family members, friends, neighbors, co-workers and others (Gaino et al., 2019). The social support network, in turn, consists of the set of persons or institutions that the individual realizes that they can trust or count for the provision of care, love and values. Studies have been developed on the effects of social support on people's health, associating it with different health outcomes. Such a construct has been related to better abstinence rates and decreased use of drugs, as well as to the abandonment of behaviors harmful to health (Cherry, 2020).

Social support networks among those living with psychiatric disorders area units are generally smaller and additional restricted and primarily incorporate kin as compared with the general population (Hamza et al., 2022). Social support will be crucial for persons with psychiatric diseases who rely on family, friends, or organizations to help them with everyday activities, provide companionship, and care for their wellbeing (Chronister, Fitzgerald & Chou, 2021). Accumulated social support, and active social policy that facilitates social support, are important dimensions in battling increased inequality in health and facilitating mental health recovery among psychiatric patients (Bjørlykhaug et al., 2021).

Individuals with severe mental health disorders may have less social support than others. The interruption of interpersonal interactions is one of the most devastating consequences of psychiatric diseases. This can be speculated by the finding of the present study which illustrated that two thirds of the studied psychiatric patients perceived a low level of social support. This may be related to that; nearly two thirds of studied psychiatric patients were single.

This interpretation is supported by other research conducted by Ritter, Hilliard & Knox, (2022) who stated that involvement in a romantic relationship is predictive of higher perceived social support. This is most likely due to stigma and discrimination, which have a direct impact on people with mental illnesses' social opportunities. Individuals with psychiatric problems have a reduced perceived social support, which

may reflect the reality that these patients require social support to confront life's challenges.

This study result revealed that, the highest social support perceived by studied patients was from their families. This is properly may be due to that family ties are strong in the Middle East and this can play a positive role to the extent that they are used as social support rather than social pressure. Many people with serious mental illness either live with their families including parents, spouses' siblings, and children or have regular ongoing contact with their families. This result was supported by El-Monshed and Amr (2017). They studied Association between perceived social support and recovery among patients with schizophrenia and found that, the subjects mention their closest relatives as the most frequently used supporters.

The present study found that, the studied patients secondly perceived social support from significance others. This may be due to the fact that, significance others may include any special persons in the patient's life such as a boyfriend/girlfriend, a doctor, a nurse or clerk and support psychiatric patients more than their family members, while the present study showed that ,most of the studied patients perceived a low social support from friends. This may be attributed to that most of friends may cut their relationships with psychiatric patients because of the negative view of psychiatric illness in the community. Egyptian society still fears insanity and crazies, despite being all around.

In the same line, Mahmoud, Berma, & Gabal (2017) conducted study entitled "Relationship between Social Support and the Quality of Life among Psychiatric Patients" and they supported this result and reported that, significance to others were the most numerous group who provided support and close relatives come second(Mahmoud et al., 2017).

In relation to total social support level, the present study revealed that, two thirds of patients had a low social support level. This is probably may be due to stigma and discrimination, which have a direct effect on the social opportunities of people with mental illness. Also, the public does not understand the impact of mental illness and frequently fears persons with these disorders.

The present study corroborates a prior study in Egypt by El- Azzab and Ali (2021) who conducted a study entitled" social support, coping with stress and medication among

patients with bipolar disorder" and reported that the majority of patients had a poor social support level. Also, Vaingankar et al. (2020) revealed that low self-rated perceived social support was associated with all mood and anxiety disorders. Likewise, Ioannou, Kassianos, and Symeou (2019) conveyed that, the depressed patients had a low level of perceived social support. Differently, another study concluded that, patients with mental illness who have recovered and are integrated in communities have social support from families, friends, and workplaces (Chow & Priebe, 2013).

According to the study results, social support includes supportive family, friendship networks, and supportive significant others and all of them are associated with better levels of recovery. This may not be surprising as family is more consistent in supporting patient through the illness course, which indicated that family to a larger extent keep in supporting.

To conclude, satisfied interactions with family, friends, and significant others are a malleable factor that could be targeted for early intervention. Results are consistent with previous research showing that social support is correlated to better recovery for patients with mental illnesses (Bjornestad et al., 2017).

According to the study results, regarding recovery, nearly three quadrants of psychiatric patients had low psychological recovery. This may be attributed to more than one explanation. First, more than half of patients are unemployed, and improved social support at employment improves recovery outcomes. Second, also more than half of psychiatric patients cannot read or write, and inadequate education is linked to a low socioeconomic background, which has an impact on recovery.

Along with the same line, Yu et al. (2020) conducted a study entitled "personal recovery and its determinants among people living with schizophrenia in China" and found that patients' personal recovery was determined to be relatively low. This finding is in the same line with the results of Iasielloa, Agterena, Keyesd, and Cochrane (2019) concluded that mentally ill patients who maintained the lowest level of positive mental health were less likely to recover from mental illness when compared to those who maintained the highest level of positive mental health. Conversely, Kaplan, Salzer, and Brusilovskiy (2012) reported that mentally ill adults had higher scores on the recovery.

Awide range of theoretical studies that recovery in psychiatric patients could also be partially tormented by many factors that square measure according to the present study. Recovery score was higher in females than males within the current study. This can be a result of the fact that women develop such diseases later in life than men. Consistent with the forgoing current study results, prior researches confirmed that being female is a positive prognostic factor for schizophrenia. For example, Gathaiya, Mwaura, and Wagoro (2018) reported that relapses in males were twice than females who had schizophrenia.

Additionally, Mrizak, Ouanes, Lakhal, Rafrafi, and El-Hechmi (2014) stated that of females with schizophrenia had higher rates of recovery. This may be incompatible with Yu et al. (2020) who reported that male was considerably and severally related to higher personal recovery. This discovery calls for more investigation into gender-based recovery studies and the mechanisms underlying the relation between gender and recovery in psychiatric patients.

Awide range of theoretical studies that recovery in psychiatric patients could also be partially tormented by many factors that square measure according to the present study. Recovery score was higher in females than males within the current study. This can be a result of the fact that women develop such diseases later in life than men. Another clarification in the feminine advantage in hormones and organic variations of the brain (Mrizak et al., 2014). These findings match those of research conducted by Gathaiya et al., (2018) that reported that male schizophrenic patients had a double variety of relapses as compared to feminine patients. This may be incompatible with Yu et al. (2020) who reported that male was considerably and severally related to higher personal recovery. This discovery calls for more investigation into gender-based recovery studies and the mechanisms underlying the relation between gender and recovery in psychiatric patients.

Additional analyses revealed some interesting findings. Married psychiatric patients significantly had a high recovery level. These results give new insights into marital status as a vital think about understanding recovery processes and providing care to facilitate these processes. This can be partially explained by the fact that married protection would counsel that it is the presence of support in an exceeding wedding that facilitates higher psycho-logical health, whereas causing suggests it's the loss of previous support that lead to lower levels of psychological wellbeing in the formerly married (Soulsby & Bennett, 2015). This result goes along with Ran et al. (2017) who reported there's an association

between being married and improved patient outcomes,and recommended that, marriage can help people with psychiatric disorders improve their family-based support as well as their community tenure, it's critical to provide programs that make it easier for them to marry and stay married. Given the potential benefits of marriage in terms of recovery, the study also emphasizes the importance of providing appropriate services to single patients with psychiatric disorders to improve recovery.

In general, social support networks have been recognized as an important component of the recovery process (Gathaiya et al., 2018).The main finding was that there was a statically significant correlation between perceived social support total and total of recovery among patients with psychiatric disorders. It is suggested that social support can improve people's quality of life and subjective well-being by allowing them to develop and employ effective coping and problem-solving approaches (El-Azzab &Ali, 2021). This may not be surprising as social support is essential for the prevention of mental health issues, the maintenance of good mental health, and the recovery from psychiatric disorders (Bjo̊rlykhaug et al., 2021). It is possible that these findings indirectly reflect the influence of broader integration of social support orientation and the recovery approach in services and policy that guides mental health treatment today for enhancing recovery.

In the same line with this study, Skar-Fro€ding et al., (2021) conducted study about the importance of personal recovery and perceived recovery support among service users with psychosis and reported that, recovery was significantly associated with higher perceived social support. Additionally, El-Bilsha, El-hadidy & Aid (2021) stated that majority of the patients who had low social support had a frequent admission to psychiatric hospitals. It's crucial to discover out where the patient gets thier social support. This will assure that the adequate social support, encouragement, and treatment are provided. This is frequently a malleable problem that could benefit from early intervention (Hengartner et al., 2016).

CONCLUSION AND RECOMMENDATIONS

Based on the findings of the current study, it can be concluded that there were statistically positive correlations between the total score of perceived social support and the total score of psychological recovery.

In the light of the results of the present study, the following recommendations were suggested:

- Training psychiatric nurses on the importance of assessment of social support and the inclusion of assessment questionnaires in the record of patients with psychiatric disorders.
- Designing and applying psycho-education programs to encourage psychiatric patients to create meaningful interactions to seek is a viable strategy for regaining recovery.
- Planning and implementation of public health awareness programs for developing, testing, and implementing strategies to improve social support, these programs should be available in schools, universities, social groups, religious institutions, and the media to people of all social classes and cultures.
- Programs to educate caregivers about their supportive role in giving care to psychiatric patients.
- Personalized therapies targeted at promoting recovery in patients with psychiatric problems should be the focus of future research.

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العلاقة بين الدعم الاجتماعي ومستويات التعافي لدي مرضى الاضطرابات النفسية

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الخـــلاصـــــــــــــة

يعد الدعم الاجتماعي عنصرا هاما في تعافي المرضى الذين يعانون من اضطرابات نفسية. هناك نقص في الدراسات التي تبحث في التأثير النسبي للعوامل المرتطبة بالدعم الاجتماعي. إن حل هذه التشابكات يمكن أن يعزز تعافي المرضى النفسيين. **الهدف:** تهدف هذه الدراسة إلى اتكشاف العلاقة بين الدعم الاجتماعي ومستويات التعافي لدى المرضى الذين يعانون من اضطرابات نفسية. **طرق وادوات البحث:** أجريت هذه الدراسة الوصفية الترابطية على 162 مريضًا نفسيًا من العيادة الخارجية لمستشفى بورسعيد للصحة النفسية وعلاج الإدمان، مصر. تم استخدام أداتين لجمع البيانات وهى مقياس متعدد الأبعاد للدعم الاجتماعي المتصورومقياس تقييم مستويات التعافي، بالإضافة إلى استمارة البيانات الشخصية والاكلينكية. **النتائج:** اوضحت الدراسة ان ثلثي المرضى النفسيين الذين شملتهم الدراسة يتمتعون بمستوى منخفض من الدعم اجتماعي، حوالى ثلاثة أرباع العينة كان لديهم مستوى قليل من التعافي **الاستنتاج والتوصيات:** خلصت الدراسة الى وجود علاقة ترابطية إيجابية ذات دلالة إحصائية بين الدعم الاجتماعي المتصور ومستويات التعافي للمرضى النفسيين. ولذلك، يوصى بتعزيز الدعم الاجتماعي أثناء رعاية المرضى النفسيين لاستعادة تعافيهم. علاوة على ذالك فاننا بحاجة إلى مزيد من الدراسات لتحسين التعافى ادى المرضى النفسيين.

الكلمات المرشدة: المرضى النفسيون، التعافي والدعم الاجتماعي.