Perceived Social Support and Its Effect On Psychiatric Patients' Recovery

Huda Gaber Hamza[1], Abeer Elsayed Berma[2], Sohier Goda El-said[3]

[1] *Lecturer, Psychiatric Nursing and Mental Health, Faculty of Nursing, Port Said University, Egypt*

[2] *Assistant professor, Psychiatric Nursing and Mental Health, Faculty of Nursing, Port Said University, Egypt*

[3] *Assistant professor, Psychiatric Nursing and Mental Health, Faculty of Nursing, Port Said University, Egypt*

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:** The current study intended to explore the relation between perceived social support and recovery among patients with psychiatric disorders. **Subjects and Method: Design:** A descriptive correlational research design was used. **Setting:** Port Said Psychiatric Health and Addiction Treatment Hospital. **Subjects:** The studied subjects compromised 90 patients with psychiatric disorders. **Tools:** Data were collected by the use of three tools namely, a personal and clinical data questionnaire, a Multidimensional scale of perceived social support, and a Recovery assessment scale −domains and stages. **Results:** Most of the psychiatric patients in this study had low perceived social support. Participants had a mean total recovery score of 76.10 ± 20.08. **Conclusion:** 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. **Recommendations:** Enhancing social support while caring for psychiatric patients is recommended to regain recovery. Further studies are needed to improve recovery for psychiatric patients.

Keywords: Perceived social support, Psychiatric patients, Recovery.

Introduction

Mental illnesses affect roughly one-third of the world's population (29.2%) [(1)], resulting in significant worldwide burden, disability, loss of productivity, morbidity, and mortality [(2)]. Psychiatric patients have fewer social contacts, often of lower perceived quality than individuals without such diseases [(3)]. People with mental illnesses have poor social outcomes because they are more vulnerable to social dysfunction, weak social networks, and interpersonal issues [(4)]. 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 [(5)].

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 [(6)]. 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 [(7)]. When measuring social support, it's important to distinguish between received and perceived support. 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 [(8)]. Social support has been highlighted as a crucial healing tool and a critical source of psychological well-being [(9)].

Recovery is rated the top possible result for mental patients, suggesting a long period without any psychiatric symptoms and adequate occupational and social functioning [10]. 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 [11]. 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) [12].

Social support is an important treatment factor in the recovery of people with psychiatric disorders [13]. 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 [14]. Patients with more social support are less likely to be admitted to a psychiatric institution, whether voluntary or involuntary [15]. Social support is one of the proposed interventions which turned into used to reduce the impact of an event specified in causing mental illness [16]. During the COVID-19 crisis, the absence of social support for those with serious mental illness has only become worsened [17].

World Health Organization (WHO) 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 [18]. 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 [19].

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 [13].

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 [16]. Patients with upright social support show better recovery and functionality [20]. 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 [9]. Thereupon, this study aimed to explore the relation between perceived social support and recovery among patients with psychiatric disorders.

Aim of the study

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

Research Objectives:

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

Subjects and Method

Study Design:

This study used a descriptive correlational research design.

Study Settings:

The current study was conducted in an outpatient clinic at Port Said Psychiatric Health Hospital, Egypt. It is affiliated with the General Secretariat of Mental Health and Addiction Treatment (GSMHAT), Ministry of Health. The hospital provides care to psychiatric patients and substance abusers. The hospital composes five inpatient psychiatric departments (three for male and two for female psychiatric patients) and one men's department for substance abuse. Moreover, one outpatient clinic for children and lastly, the psychiatric outpatient clinic which is accessible six days per week from 10 a.m. to 2 p.m.

Study Subjects:

The study subjects were a convenient sample of 90 patients with psychiatric disorders who attended the psychiatric outpatient clinic in the previously mentioned hospital.

Criteria of the subjects' recruitment:

- Diagnosed with psychiatric disorders (e.g. schizophrenia, major depressive disorder, bipolar disorder, and anxiety disorder for a duration not less than one year
- Aged 18 years or more.
- Able to communicate verbally to be able to fill all the study instruments.

Sample Size:

The following equation is used to calculate it [21].

$$n = \left[\frac{Z_{\alpha/2} + Z_{\beta}}{\frac{1}{2}\log\frac{1+r}{1-r}}\right]^2 + 3$$

.

Where

n=sample size

Z α/2 = 1.96

Zβ = 0.85

r =.56 [9]

Sample size (n) = 90 patient with psychiatric disorders

Data collection tools:

A personal and clinical data Questionnaire, Multidimensional Scale of Perceived Social Support (MSPSS), and Recovery Assessment Scale –Domains and Stages (RAS-DS) were used to collect data for this study.

Tool I: Personal and Clinical Data Questionnaire:

The authors developed an Arabic version of this structured interview questionnaire. It elicits personal characteristics such as the patient's age, gender, marital status, educational level, employment status, family income, and living conditions. It also comprised questions that cover data related to clinical characteristics including diagnosis, duration of the disorder, and numbers of previous psychiatric hospitalization.

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

Multidimensional Scale of Perceived Social Support (MSPSS) was developed by Zimet, Dahlem, Zimet, & Farley (1988) [22] and translated into Arabic by Merhi & Kazarian (2012) [23]. It is a 12-item instrument designed to assess perceptions of social support from three specific sources: family, friends and significant other. Social support from family statements number (3, 4, 8, 11), social support from friends statements number (6, 7, 9, 12), and social support from

significant other statements number (1, 2, 5, 10).

The Arabic version of MSPSS showed validity and worthy internal consistency. The internal consistencies of Family, Friends, and Significant Others as sources of social support for the total sample were high (α = .82, α = .86 and α = .85 respectively). Validity was done by an expert panel that decided that the scale was valid [22].

For the scoring system:

The MSPSS scale is rated on a 7 – Likert scale with a range from very strongly disagree = 1, to very strongly agree = 7. Scores for the total items were summed to determine the level of social support of psychiatric patients. The minimum and the maximum score is ranged between 4 and 28 for each subscale. A higher score indicates higher perceived social support. A critical value of 60% is indicated as the optimal cut-off point for assessing perceived social support. The patient's social support was considered high if the percentage was 60% or more and low if less than 60%.

TOOL III: Recovery Assessment Scale – Domains and Stages (RAS-DS)

Recovery Assessment Scale –Domains and Stages (RAS-DS) was developed by Corrigan, Salzer, Ralph, Sangster, & Keck (2004) [24] in An English language. It is a 38-item self-report instrument measuring recovery from serious mental illness.

Intended for scoring system, the **RAS-DS** is a Likert type scale with 4 options for patients to choose from: "completely true (4)", "mostly true (3)", "a bit true (2)", and "untrue (1)". The tool has 4 recovery domains; Doing Things I Value (functional recovery) (6 items), Looking Forward (personal recovery) (18 items), Mastering My Illness (clinical recovery) (7 items), and Connecting and Belonging (social recovery) (7 items). A total score of RAS-DS ranges from 38 to 152. A higher score indicates higher levels of recovery. Domains of RAS-DS have different numbers of items so the score of each domain is converted to a percentage (%) to be most useful to see variance across domains [25].

Validity and Reliability of the Study Tool (III):

For the aim of the contemporary study, the RAS-DS **(Tool III)** was translated into the Arabic language. The two main stages of translation encompassing forward and backward were completed. Two bilingual experts did the forward translation, and then the Arabic version of the RAS-DS was then translated back into An English language by two other linguistic specialists who were unaware of the original version. Then, the researchers reviewed these translations and compared them with the original version to assure the accuracy of the translation and eradicate any differences.

Besides, a final Arabic version was evaluated by a panel of experts who decided that the translated instrument was valid. A board comprised one professor and two assistant professors from the Psychiatric Nursing and Mental Health department, Faculty of Nursing, two professors from the Psychiatric Medicine department, Faculty of Medicine, and two assistant professors from the Psychology department, Faculty of Arts, Port Said University. They were called to convey their outlooks regarding the construction, lucidness, implication, and extensiveness of the translated instrument. Based on their evaluation, the required notes were taken into consideration accordingly. The stage of evidencing the validity of the translated tool continued for one month.

Reliability:

An Arabic version of the RAS-DS was evidenced to be reliable as Cronbach's alpha coefficient was reasonable as α = 0.87. The period of confirming reliability continued for one week.

Pilot Study:

In preparation for the actual study, a pilot study was implemented on 10 % of the studied Patients (No. 9) who suffered from psychiatric disorders. It was carried out to

ascertain the importance, clarity, and applicability of the study tools in use, as well as to determine the time needed to fill them out. The patients who encompassed the pilot study were not included in the chief study sample to assure the stability of the result. The study tools were not changed as a result of the pilot study's findings. The study tools were simple and clear. The pilot study started on 1, January2021, and lasted for two weeks.

Data Collection Process:

Originally, an official letter was issued from the Dean of the Faculty of Nursing; at Port Said University to the Director of the above-mentioned setting requesting his/her collaboration and permission to conduct the study, after duly elucidating the drive of the study. Consequently, the director referred the researchers to the responsible nurse of each department, and the researchers attended each responsible nurse's office to introduce themselves, clarify the aim of the study, and pursue an agreement. After that, the researchers interviewed patients who had psychiatric disorders who met the inclusion criteria and provided their informed consent. The data were collected over 3 days/ week (Sunday, Monday, and Tuesday). The collection of data covered four months from the first of March 2021 to the end of June 2021.

The data collection procedure was conducted utilizing a face-to-face interview method that was done on an individual basis and this was done in a private area in the outpatients departments to ensure discretion and confidentiality of the collected data. A number of vacillating from 3 to 4 psychiatric patients were interviewed daily from 10 a.m. to 2.00 p.m. Each tool lasted from 20 to 25 minutes to be filled out depending on patients' responses. After accomplishment, the researchers ensured that all items involved in the study tools were completed. Then, the studied patients were acknowledged for the time and effort they kindly offered.

Ethical Considerations:

The Scientific Research Ethics Committee of the Faculty of Nursing at Port Said University approved the study protocol. Following a thorough explanation of the study's goal and nature, the patients gave their informed consent. Every patient had an equal chance to be involved in the study through randomization. Confidentiality of the collected data and anonymity were strictly maintained through a code number affixed to each studied patient's questionnaire. The patients' willingness to participate was confirmed because they were informed that they might withdraw from the study at any time. Finally, the process of data collection was not disturbing the harmony of the work in the above-mentioned setting.

Statistical Analysis

Data were fed to the computer and analyzed using IBM SPSS software package version 20.0. (Armonk, NY: IBM Corp) Qualitative data were described using numbers and percent. The Kolmogorov-Smirnov test was used to verify the normality of distribution. Quantitative data were described using range (minimum and maximum), mean, and standard deviation. The significance of the obtained results was judged at the 5% level. A Chi-square test was used for categorical variables, to compare between different categories. Fisher’s Exact or Monte Carlo correction for chi-square when more than 20% of the cells have an expected count of less than 5. For normally distributed quantitative variables, a t-test was used to compare two studied categories and one way ANOVA test to compare between more than two categories. An Arabic version of **RAS-DS** internal consistency was assessed by measurement of Cronbach’s alpha coefficient. Besides, Pearson coefficient to

correlate between two normally distributed quantitative variables was utilized. Regression analysis was applied to detect the most independent factors affecting recovery with 95% confidence interval.

Results

Table 1: Reveals the studied psychiatric patients' personal characteristics, the study group comprised 90 patients, and more than half (64.4%) of them were females and single which constituted 64.4 % and 66.7 % respectively. Concerning their employment status, 80 % of the studied patients were unemployed. Looking at their living status, more than half, (66.7%) of the studied patients were living with family members.

Table 2: Displays the studied psychiatric patients' clinical characteristics, Results reveal that 63.3% of the studied subjects were diagnosed with schizophrenia. Concerning the duration of disorder among the studied patients, nearly one-third of the studied patients (35.6%) had a diagnosis of psychiatric disorders since less than 5 years. Also, more than two-thirds (70.0 %) of the studied psychiatric patients had the previous hospitalization in psychiatric hospitals.

Figure 1: It was vibrant from the figure that the majority of the studied psychiatric patients (91.1%) perceived a low level of social support. whereas only 8,9 % perceived a high level of social support.

Table 3: Elicits that the psychiatric patients' functional recovery, personal recovery, clinical recovery, and social recovery mean scores constituted 12.78 ± 4.30, 35.34 ± 10.73, 13.92 ± 4.63, and 14.06 ± 4.69 respectively. Also, the mean score of total recovery was 76.10 ± 20.08.

Table 4: Puzzles out the relation between mean scores of total recovery and personal characteristics among the studied psychiatric patients. The study results reveal that there was a statistically significant relation between mean scores of total recovery and personal characteristics of the studied patients concerning sex, marital status, employment status, and living status wherever $p \leq 0.05$.

Table 5: Reveals the relation between mean scores of total recovery and clinical characteristics among the studied psychiatric patients. The table considers that there were statistically significant relations between mean scores of total recovery and clinical characteristics of the studied patients comprising department, diagnosis, and previous hospitalization at $p \leq 0.05$.

In table 6: It was evidenced that both perceived social support subscales and the total score had a statistically significant positive correlation with recovery whereby $p \leq 0.05$.

Table 7: For factors affecting recovery among the studied psychiatric patients, as remarked, the strong factor affecting recovery among psychiatric patients was social support from friends followed by social support from family and significant others whereby ($p = 0.091$, 0.662, and 0.886) respectively.

Table (1): Frequency & percentage distribution of the studied patients according to their personal characteristics (n=90)

Personal characteristics	No.	%
Gender		
Male	32	35.6
Female	58	64.4
Age (years)		
20 – < 30	31	34.4
30 – 40	37	41.1
> 40	22	24.4
Marital status		
Single	60	66.7
Married	12	13.3
Divorced	14	15.6
Widow	4	4.4
Levels of education		
Not read and write	35	38.9
Read and write	9	10.0
Basic education	24	26.7
Secondary education	22	24.4
Employment status		
Employed	18	20.0
Unemployed	72	80.0
Family income/ month		
Enough	35	38.9
Not enough	55	61.1
Living Status		
Alone	30	33.3
With family	60	66.7

Table (2): Frequency & percentage distribution of the studied patients according to their clinical characteristics (n=90)

Clinical characteristics	No.	%
Diagnosis		
Schizophrenia	57	63.3
Bipolar disorder	33	36.7
Duration of disorder (years)		
< 5	32	35.6
5 – 10	29	32.2
> 10	29	32.2
Previous hospitalization		
Yes	63	70.0
No	27	30.0
If yes, Number of pervious hospitalization	**(n = 63)**	
1 – 2	7	11.1
3 – 5	34	54.0
>5	22	34.9

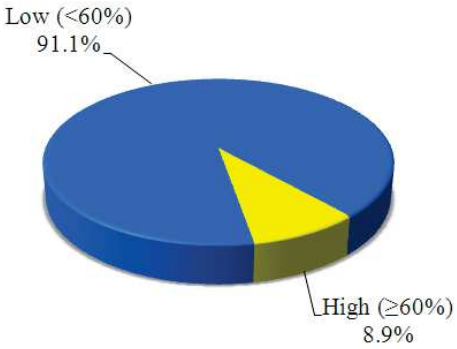

Figure (1): Percentage distribution of the studied patients according to levels of perceived social support

Table (3): Mean Scores of recovery among the studied patients (n = 90)

Recovery	Total Score	Mean Score	% Score
	Mean ± SD.	Mean ± SD.	Mean ± SD.
Functional Recovery	12.78 ± 4.30	2.13 ± 0.72	37.65 ± 23.89
Personal Recovery	35.34 ± 10.73	1.96 ± 0.60	32.12 ± 19.87
Clinical Recovery	13.92 ± 4.63	1.99 ± 0.66	32.96 ± 22.04
Social Recovery	14.06 ± 4.69	2.01 ± 0.67	33.60 ± 22.34
Total Recovery	76.10 ± 20.08	2.0 ± 0.53	33.42 ± 17.61

Table (4): Relation between mean scores of total recovery and personal characteristics among the studied patients (n =90)

Personal characteristics	No.	%	Mean Scores of recovery (Total score)	Test of Sig.	P
			Mean ± SD.		
Gender					
Male	32	35.6	68.97 ± 17.80	t= 2.581*	0.012*
Female	58	64.4	80.03 ± 20.32		
Age (years)					
20 – < 30	31	34.4	70.39 ± 17.85	F= 2.672	0.075
30 – 40	37	41.1	76.78 ± 19.48		
> 40	22	24.4	83.00 ± 22.45		
Marital status					
Single	60	66.7	75.85 ± 18.98	F= 4.382*	0.006*
Married	12	13.3	91.75 ± 21.15		
Divorced	14	15.6	68.07 ± 16.98		
Widow	4	4.4	61.00 ± 20.05		
Levels of education					
Not read and write	35	38.9	81.34 ± 20.70	F= 2.274	0.086
Read and write	9	10.0	81.33 ± 24.44		
Basic education	24	26.7	73.42 ± 17.88		
Secondary education	22	24.4	68.55 ± 17.66		

Employment status					
Employed	18	20.0	86.00 ± 19.83	t= 2.401*	0.018*
Unemployed	**72**	**80.0**	**73.63 ± 19.50**		
Family income/ month					
Enough	35	38.9	74.83 ± 16.72	t= 0.507	0.613
Not enough	55	61.1	76.91 ± 22.06		
Living Status					
Alone	30	33.3	69.07 ± 19.43	t= 2.413*	0.018*
With family	60	66.7	79.62 ± 19.62		

t: Student t-test F: F for ANOVA test *: Statistically significant at p ≤ 0.05

Table (5): Relation between mean scores of total recovery and clinical characteristics among the studied patients

Clinical characteristics	No.	%	Mean Scores of recovery (Total score) Mean ± SD.	Test of Sig.	p
Diagnosis					
Schizophrenia	57	63.3	80.67 ± 20.89	t= 3.171*	0.002*
Bipolar disorder	33	36.7	68.21 ± 16.01		
Duration of disorder (years)					
< 5	32	35.6	76.03 ± 16.76	F= 0.071	0.932
5 – 10	29	32.2	75.14 ± 22.20		
> 10	29	32.2	77.14 ± 21.81		
Previous hospitalization					
Yes	63	70.0	71.89 ± 18.78	t= 3.192*	0.002*
No	27	30.0	85.93 ± 19.88		
If yes, the Number of previous hospitalization	**(n = 63)**				
1 – 2	7	11.1	93.71 ± 16.92	F= 2.888	0.063
3 – 5	34	54.0	76.71 ± 23.06		
>5	22	34.9	71.73 ± 18.80		

t: Student t-test F: F for ANOVA test *: Statistically significant at p ≤ 0.05

Table (6): Correlation between perceived social support and recovery among the studied patients

perceived social support		Recovery				
		Functional Recovery	Personal Recovery	Clinical Recovery	Social Recovery	Total Recovery
Social support from family statements	r	0.138	0.294*	0.088	0.229*	0.260*
	p	0.195	0.005*	0.407	0.030*	0.013*
Social support from	r	0.278*	0.370*	0.137	0.147	0.323*

friends statements	**p**	0.008*	<0.001*	0.198	0.166	0.002*
Social support from significant others	**r**	0.241*	0.321*	0.071	0.115	0.266*
	p	0.022*	0.002*	0.509	0.279	0.011*
Total social support	**r**	0.237*	0.355*	0.107	0.179	0.307*
	p	0.025*	0.001*	0.316	0.092	0.003*

r: Pearson coefficient

*: Statistically significant at p ≤ 0.05

Table (7): Multiple linear regression analysis of factors affecting recovery among the studied patients

Sources of Perceived Social Support	B	SE	Beta	T	p	95% CI	
						LL	UL
family	0.060	0.137	0.079	0.439	0.662	-0.212	0.333
friends	0.232	0.136	0.291	1.707	0.091	-0.038	0.502
significant others	-0.024	0.165	-0.030	0.144	0.886	-0.353	0.305
R^2=0.107 F =3.420*, p=0.021*							

F,p: f and p values for the model — R^2: Coefficient of determination

B: Unstandardized Coefficients — SE: Estimates Standard error

Beta: Standardized Coefficients — t: t-test of significance

CI: Confidence interval

LL: Lower limit — UL: Upper Limit

*: Statistically significant at p ≤ 0.05

Discussion

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 [(26)]. 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 well-being [(27)]. 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 [(20)].

Individuals with severe mental illnesses may have less social support than others [(3)]. 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 majority of the studied psychiatric patients perceived a low level of social support. This may be related to that; Majority of studied psychiatric patients were single. This interpretation is supported by other research conducted by Adamczyk, & Segrin (2015) [28] 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.

The present study corroborates a prior study in Egypt by El- Azzab and Ali (2021) [29] 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) [19] revealed that low self-rated perceived social support was associated with all mood and anxiety disorders. Likewise, Ioannou, Kassianos, and Symeou (2019) [30] conveyed that depressed patients had a low level of perceived social support. Differently, Ali et al. (2010) [27], showed that family perceived social support was higher among persons with somatization**.** Support from family, friends, and significant others was the crucial system to provide support, and their relationships should be encouraged as an important part of service delivery to families dealing with psychiatric disorders.

One of the imperative findings of the existing study was that, in this study, the mean recovery score was significantly lower than that of a similar community sample of psychiatric patients in Egypt and using the RAS-DS scale for assessing recovery [10]. This may be attributed to more than one explanation. First, the majority of patients are unemployed, and improved social support at employment improves recovery outcomes. Second, the majority of psychiatric patients cannot read or write, and inadequate education is linked to a low socioeconomic background, which has an impact on recovery. This explanation was supported by Falco, Dal Corso, Di Sipio, and Alberto De Carlo, (2013) [31] and Chabungbam, Avasthi, and Sharan (2007) [32]. The study's findings highlighted the importance of improving outcomes among patients with psychiatric disorders, including interventions that assume a recovery orientation, make substantial efforts to engage individuals in treatment, and monitor recovery outcomes. This necessitates that each stakeholder is concerned about and collaborates on the various aspects that influence recovery in patients with psychiatric disorders.

Along with the same line, Yu et al. (2020) [33] 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) [34] 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) [35] reported that mentally ill adults had higher scores on the recovery. It could

also indicate variation in recovery levels among different samples, as evidenced by Kaplan et al. (2012) [35] study showing that recovery scores vary by country.

It will be deducted from a wide 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 is the feminine advantage in hormones and organic variations of the brain [16]. These findings match those of research conducted by Gathaiya, Mwaura, and Wagoro, (2018) [36] 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) [33] 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 [37]. This result goes along with Ran et al. (2016) [38] who reported there's an association between being married and improved patient outcomes. Furthermore, Ran et al. (2016) [38] 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.

Family members often provide significant support and care to their relative who has psychiatric disorders which foster recovery. The findings of the study revealed that people who live with family have a benefit over those who live alone in terms of recovery. This finding should be taken into account when developing clinical care and social interventions for people with psychiatric disorders. It's reasonable to assume that social support, particularly emotional support from a close relative, is one of the most essential protective factors against mental illness [39].

These results supported previous findings from similar studies and suggested that housing is also recognized as a critical element in clinical and personal recovery [40]. The needs of different family members and the needs of the family as a group should be considered concurrently alongside psychiatric patients' needs in their recovery plan [41]. When considering the association between psychiatric disorders and recovery, the type of psychiatric disorders appeared as a key factor. Specifically, the Recovery percentage was significantly high among schizophrenic patients in this study. This could be explained by the fact that up to half of schizophrenic individuals have positive outcomes and can have a productive and fulfilling life despite their disease [33]. Another rationale is that individuals with schizophrenia now have access to a wide range of pharmacological and psychosocial therapies that may eventually satisfy the unique demands of each patient profile, therefore increasing the

probability of successful treatment [42]. A further interpretation is that the positive influence of long-acting antipsychotics on adherence, as well as the closer contact between schizophrenia patients and the healthcare team connected with their dosing, have been regarded as beneficial for functional recovery [43].

This result agrees with a study in Egypt by Mahmoud, Ali, and Hafez, (2021) [44] who studied "Relation between the level of hope and functional recovery among patients with schizophrenia" and who conveyed that most of the schizophrenic patients have a high level of functional recovery. Accordingly, another study indicated that schizophrenic patients had higher clinical, societal, and personal recovery [45]. Contradictory findings were found by Grover et al. (2016) [46] who concluded that patients of bipolar disorders experienced higher level of recovery compared to schizophrenia.

In general, social support networks have recently been recognized as an important component of the recovery process [26]. The main finding was that there was a statically significant correlation between perceived social support total and subscales and 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 [39]. 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 [20]. 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, El-Bilsha, El-hadidy, and Aid (2021) [47] assessed 200 patients with bipolar disorder evaluating social support and its relevance to relapse among patients with bipolar disorder" in Egypt, and found that majority of the patients who had low social support had a frequent admission to psychiatric hospitals. Also, another study concluded that recovery was significantly associated with higher perceived social support [48]. Additionally, Corrigan and Phelan (2004) [49] stated that both a process perspective on recovery was significantly associated with objective and subjective indicators of social support. It's crucial to discover out where the patient gets his or her 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 [50].

Finally, and most importantly, in the current study, the most factor affecting recovery is perceived social support from friends followed by perceived social support from family and significant others among psychiatric patients. This finding does not deny the importance of family support in the lives of persons suffering from psychiatric disorders. One explanation could be that emotional support from friends who can provide empathy and consolation during stressful situations has repeatedly been connected to optimal mental health and recovery [19, 51]. This is particularly important given our findings that social support from friends, family members, and significant others is linked to psychiatric patients' recovery.

In line with this finding, previous research has illustrated that peer support is shown to have statistically significant benefits on recovery for mentally ill patients [52]. This result was consistent with Grbic, Simetin, and Istvanovic (2020) [53] who assess the importance of peer support in the recovery process of persons with mental disorders and finished that peer play a very important role within the recovery method.

Also, Bjørnestad et al. (2017) [51] found that the frequency of relationship interaction foretold clinical recovery. In this respect, the maintenance of a study peer support services in health care would solely be attainable through cooperative efforts and in-progress support and engagement from all health care practitioners, managers, and alternative stakeholders [54].
One attainable intervention might embody co nsistently incorporating peer support into the health care system by asking them to commit to interacting with psychiatric patients on a frequent basis at an early stage of treatment to improve engagement, quality of life, self-confidence, and integrity; and to scale back the burden on the health care system and foster recovery.

Conclusion To conclude, the present study illustrates that there were statistically noteworthy positive correlations between the total score of perceived social support plus its subscales and recovery among the studied psychiatric patients. As well, the predictor that had a noteworthy effect on recovery was friend's social support followed by family and significant social support

Recommendations From the results of the existing study, the following recommendations are suggested:

1- 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.
2- Designing and applying psycho-education programs to encourage psychiatric patients to create meaningful interactions to seek is a viable strategy for regaining recovery.
3- 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.
4- Programs to educate caregivers about their supportive role in giving care to psychiatric patients.
5- Personalized therapies targeted at promoting recovery in patients with psychiatric problems should be the focus of future research.

References

1. Steel Z, Marnane C, Iranpour C, Chey T, Jackson J. W, Patel V, Silove D. The global prevalence of common mental disorders: A systematic review and meta-analysis 1980–2013. International Journal of Epidemiology. 2014; 43(2): 476-493.
2. Charlson F, Baxter A, Dua T, Degenhardt L, Whiteford H, Vos T. Excess mortality from mental, neurological and substance use disorders in the Global Burden of Disease Study 2010. Epidemiology and Psychiatric Sciences. 2015; 24(2): 121-140.
3. Beckers T, Maassen N, Koekkoek B, Tiemens B, Hutschemaekers G. Can social support be improved in people with a severe mental illness? A systematic review and meta-analysis. Current Psychology. 2022; 1-11.
4. Wang J, Mann F, Lloyd-Evans B, Ma R, Johnson S. Associations between loneliness and perceived social support and outcomes of mental health problems: A systematic review. BMC Psychiatry. 2018; 18(1):1-16.
5. Liu N, Daumit G, Dua T, Aquila R, Charlson F, Cuijpers P, Saxena S. Excess mortality in persons with severe mental disorders: A multilevel intervention framework and priorities for clinical practice, policy and research agendas. World Psychiatry. 2017; 16(1): 30-40.
6. Roth C, Wensing M, Koetsenruijter J, Istvanovic A, Novotni A, Tomcuk Dedovic J, et al. Perceived support for recovery and level of functioning among people with severe Mental Illness in Central and Eastern Europe: An observational study. Frontiers in Psychiatry. 2021; 73211(12):1-11.
7. Reblin M, Uchino, B. Social and emotional support and its implication for health. Current Opinion in Psychiatry: 2008; 21(2): 201.
8. Uchino B, Bowen K, Carlisle M, Birmingham W. Psychological pathways linking social support to health outcomes: A visit with the “ghosts” of research past, present, and future. Social Science & Medicine. 2012; 74(1): 949–957.
9. Hendryx M, Green C, Perrin N. Social support, activities, and recovery from serious mental illness: STARS study findings. The Journal of Behavioral Health Services & Research. 2010; 36(3): 320-329.
10. El-Monshed A. Amr M. Association between perceived social support and recovery among patients with schizophrenia. International Journal of Africa Nursing Sciences. 2020; 13(100236):1-6.
11. Brogan C, Delaney G, Sweeney M. Recovery: Supporting personal recovery- the role of the psychiatrist. College of Psychiatrist of Ireland. 2019; 9-15.
12. Keet R, de Vetten-Mc Mahon M, Shields-Zeeman L, Ruud T, van Weeghel J, Bahler M, et al. Recovery for all in the community; Position paper on principles and key elements of community-based mental health care. BMC Psychiatry. 2019; 19(1): 1-11.
13. Harfush S, Gemeay E. Perceived social support and medication compliance among patients with psychiatric disorders. International Journal of Novel Research in Healthcare and Nursing. 2018; 4(3): 157–169.
14. Beljouw I, Verhaak P, Prins M, Cuijpers P, Penninx B, Bensing J. Reasons and determinants for not receiving treatment for common mental disorders. Psychiatric Services. 2010; 61(1): 250–257.
15. Van Veen M, Wierdsma A, van Boeijen C, Dekker J, Zoeteman J, Koekkoek B, et al. Suicide risk, personality disorder and hospital admission after assessment by psychiatric emergency services. BMC Psychiatry. 2019; 19(1): 157.
16. Schön U. Recovery from severe mental illness, a gender perspective. Scandinavian Journal of Caring Sciences. 2009; 24(3): 557-564.
17. Wildman E, MacManus D, Kuipers E, Onwumere J. COVID-19, severe mental illness, and family violence. Psychological Medicine. 2021; 51(1): 705–706.
18. Çam O, Yalçıner N. Mental illness and recovery. Journal of Psychiatric Nursing. 2018; 49469 (1): 55-58.
19. Vaingankar J, Abdin E, Chong S, Shafie S, Sambasivam R, Zhang J, et al. The association of mental disorders with perceived social support, and the role of marital status: Results from a national cross-sectional

survey. Archives of Public Health. 2020; 78(1): 1-11.
20. Bjørlykhaug K, Karlsson B, Hesook S, Kleppe L. Social support and recovery from mental health problems: A scoping review. Nordic Social Work Research. 2021; 1-32.
21. Dawson-Saunders B. Basic and Clinical Biostatistics. ALANGE Medical Book. 2004; 42-161.
22. Zimet G, Dahlem N, Zimet S, Farley G. The Multidimensional Scale of Perceived Social Support. Journal of Personality Assessment. 1988; 52(1): 30-41.
23. Merhi R, Kazarian S. Validation of the Arabic Translation of the Multidimensional Scale of Perceived Social Support (Arabic MSPSS) in a Lebanese community Sample. Retrieved from the Arab Journal of Psychiatry. 2012; 44(262):1-21. Available from: https:// Platform. Almanhal. Com/ Files/ 2/17306.
24. Corrigan P, Salzer M, Ralph R, Sangster Y, Keck L. Examining the factor structure of the recovery assessment scale. Schizophrenia Bulletin. 2004; 30(4): 1035-1041.
25. Hancock N, Scanlan J. N, Bundy A, Honey A. Recovery assessment scale-domains and stages (RAS-DS) manual-version 2. Sidney University. 2016.
26. Pernice-Duca F. Family network support and mental health recovery. Journal of Marital and Family Therapy. 2010; 36(1): 13-27.
27. Ali A, Deuri S, Deuri S, Jahan M, Singh A, Verma A. Perceived social support and life satisfaction in persons with somatization disorder. Ind Psychiatry J. 2010;19(1): 115-8.
28. Adamczyk K, Segrin C. Direct and indirect effects of young adults' relationship status on life satisfaction through loneliness and perceived social support. Psychologica Belgica. 2015; 55(4): 196–211.
29. El- Azzab S, Ali S. Social support, coping with stress and medication among patients with bipolar disorder. Egyptian Journal of Nursing& Health Sciences. 2021; 2 (2): 227-247.
30. Ioannou M, Kassianos A, Symeou M. Coping with depressive symptoms in young adults: perceived social support protects against depressive symptoms only under moderate levels of stress. Frontiers in Psychology. 2019; 2780.
31. Falco A, Girardi D, Dal Corso L, Di Sipio A, De Carlo N. Fear of workload, job autonomy, and work-related stress: The mediating role of work-home interference. TPM Test Psychom Methodol Appl Psychol. 2013; 20(3): 217-234.
32. Chabungbam G, Avasthi A, Sharan P. Sociodemographic and clinical factors associated with relapse in schizophrenia. Psychiatry and Clinical Neurosciences. 2007; 61(6): 587 593.
33. Yu Y, Xiao X, Yang M, Ge X. P, Li T, Cao G, et al. Personal recovery and its determinants among people living with schizophrenia in China. Frontiers in Psychiatry. 2020; 1436.
34. Iasielloa M, Agterena J, Keyesd C, Cochrane E. Positive mental health as a predictor of recovery from mental illness. Journal of Affective Disorders. 2019; 251 (2019): 227–230.
35. Kaplan K, Salzer M, Brusilovskiy E. Community participation as a predictor of recovery-oriented outcomes among emerging and mature adults with mental illnesses. Psychiatric Rehabilitation Journal. 2012; 35(3): 219.
36. Gathaiya N, Mwaura J, Wagoro M. A cross-sectional study on factors associated with relapse in patients with schizophrenia at Mathari hospital, Nairobi Kenya. Annals of Clinical and Laboratory Research. 2018; 6(1): 1-7.
37. Soulsby L, Bennett K. Marriage and psychological wellbeing: The role of social support. Psychology. 2015; 6(1): 1349-1359.
38. Ran M, Wong Y, Yang S, Ho P, Mao W, Li J, et al. Marriage and outcomes of people with schizophrenia in rural China: 14-year follow-up study. Schizophrenia Research. 2016; 182(1): 49-54.
39. Pokharel B, Pokharel A. Perceived social support among mentally ill patients. Journal of Lumbini Medical College. 2014; 2(1): 14-17.
40. Piat M, Seida K, Sabetti J, Padgett D. Placing recovery: Sites of health and wellness for individuals with serious mental illness in supported housing. Health & Place. 2017; 47(1): 71-79.

41. Waller S, Reupert A, Ward B, McCormick F, Kidd S. Family focused recovery: Perspectives from individuals with a mental illness. International Journal of Mental Health Nursing. 2018; 28(1): 247-255.
42. Peña J, Ibarretxe-Bilbao N, Sánchez P, Iriarte M, Elizagarate E, Garay M. A, et al. Combining social cognitive treatment, cognitive remediation, and functional skills training in schizophrenia: A randomized controlled trial. Npj Schizophrenia. 2016; 2(1): 1-7.
43. Lahera G, Gálvez J, Sánchez P, Martínez-Roig M, Pérez-Fuster J, García-Portilla P, et al. Functional recovery in patients with schizophrenia: Recommendations from a panel of experts. BMC Psychiatry. 2018; 18(1): 1-10.
44. Mahmoud A, Ali S, Hafez Elbaz A. Relation between the level of hope and functional recovery among patients with schizophrenia. Port Said Scientific Journal of Nursing. 2021; 8(3): 106-125.
45. Castelein S, Timmerman M, Van Der Gaag M, Visser E. Clinical, societal and personal recovery in schizophrenia spectrum disorders across time: States and annual transitions. The British Journal of Psychiatry. 2021; 219(1): 401-408.
46. Grover S, Hazari N, Singla N, Chakrabarti S, Aneja J, Sharma S, et al. Recovery among patients with severe mental illness: Factor analysis of recovery assessment scale in Indian setting. Indian Journal of Social Psychiatry. 2016; 32(2): 92.
47. El-Bilsha M, El-hadidy M, Aid A. Social support and its relevance to relapse among patients with bipolar disorder. Mansoura Nursing Journal. 2021; 8(1): 103-113.
48. Skar-Fro€ding R, Clausen H, Benth J, Ruud T, Slade M, Heiervang K. The importance of personal recovery and perceived recovery support among service users with psychosis. Psychiatric Services. 2021; 72 (6): 661-668.
49. Corrigan P, Phelan S. Social support and recovery in people with serious mental illnesses. Community Mental Health Journal. 2004; 40(6): 513-523.
50. Hengartner M, Passalacqua S, Heim G, Andreae A, Rössler W, von Wyl A. The post-discharge network coordination program: A randomized controlled trial to evaluate the efficacy of an intervention aimed at reducing hospitalizations and improving mental health. Frontiers in Psychiatry. 2016; 7(1): 27.
51. Bjornestad J, ten VeldenHegelstad W, Joa I, Davidson L, Larsen T. K, Melle I, et al. With a little help from my friends, social predictors of clinical recovery in first-episode psychosis. Psychiatry Research. 2017; 255(1): 209-214.
52. White S, Foster R, Marks J, Morshead R, Goldsmith L, Barlow S, et al. The effectiveness of one-to-one peer support in mental health services: A systematic review and meta-analysis. BMC psychiatry. 2020; 20(1): 1-20.
53. Grbic D, Simetin I, Istvanovic A. The importance of peer support in the recovery process of persons with mental disorders. European Journal of Public Health. 2020; 30 (5).
54. Shalaby R, Agyapong V. Peer support in mental health: Literature review. JMIR Mental Health. 2020; 7(6): e15572.