Association between Perceived Social Support and Recovery among Patients with Psychiatric Disorders

Amal Ahmed Diab[1], Adel Abd Elkareem Badawy [2], Mervat Hosny Shalaby[3], Eslam Mohamed Gado [4]

[1]Demonstrator of Psychiatric and Mental Health Nursing, Faculty of Nursing, Tanta University.

[2]Professor of Neuro- Psychiatry Neuro- psychiatry department Faculty of medicine, Tanta University.

[3]Professor of Psychiatric and Mental Health Nursing, Faculty of Nursing, Tanta University.

[4]Assistant Professor of Psychiatric and Mental Health Nursing, Faculty of Nursing, Tanta University.

Corresponding author: Amal Diab
E-mail: a01001632962@gmail.com

Abstract

Background: Patients with psychiatric disorders benefit greatly from social support during their recuperation. **Aim of study:** Aimed to investigate the relationship between recovery and perceived social support among patients with psychiatric disorders. **Subject and setting:** A sample of 260 psychiatric patients from the outpatient clinic of Psychiatry, Neurology and Neurosurgery Center and Psychiatric Tanta University Hospital. **Study design:** This study used a descriptive correlational research design. **Tools: study tool**, Perceived Social Support Multidimensional Scale and Recovery Assessment Scale. **Results:** The study found that roughly half of studied patients had high levels of perceived social support. Additionally, about half of the patients in the study experienced a significant degree of overall recovery; there are statistically significant positive connections between recovery and perceived social support. **Conclusion:** Social support has critical role in improving patients' recovery. **Recommendations:** Creating social support educational programs for patients with psychiatric disorders should consider as essential part of recovery process. **Key words:** Recovery, perceived social support, and patients with psychiatric disorders.

Introduction

Psychiatric disorders, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), as syndromes marked by clinically significant disturbances in an individual's cognition, emotional regulation, or behavior, indicative of dysfunction in the psychological, biological, or developmental processes that underpin mental functioning. The National Survey of Mental Disorders in Egypt assessed the overall prevalence at 24% of the examined adult population **(Mahmoud, 2025)**. Psychiatric disorders are among the most debilitating conditions globally, resulting in extended disability and impairment across personal, functional, and social dimensions **(Le & Bui, 2025)**. Patients with psychiatric problems often struggle to fulfill socialization demands, since many opt to eschew social interactions and mostly lead solitary, inactive lifestyles **(Gyamfi, Bhullar, Islam, & Usher,. 2025)**. So that, patients with psychiatric disorders encounter considerable stressors linked to isolation, diminished productivity, societal rejection, and insufficient social support **(Al-Worafi, 2024)**.

Social support encompasses a diverse array of phenomena that define the social environment and the individuals within one's network. It foster a sense of being cared for, esteemed, valued, and integrated within a network of communication and mutual obligations **(Sugie & Augustine, 2020)**. Social support encompasses two dimensions: perceived social support and received social support **(Nemcikova, Katreniakova, & Nagyova, 2023)**. Perceived social support refers to an individual's assessment the quality of assistance received from their social network, while received social support is described as the objective measurement of the help and aid provided by that network **(Gan, Wong & Jiao ., 2023)**.

Psychologists and other mental health specialists characterize perceived social support as an essential generalized resistance resource, as it provides a safety net for the patient, fosters an empathetic connection, and enhances self-confidence and a feeling of belonging **(Rippon , Shepherd, Wakefield, Lee & Pollet. 2024)**. In addition to alleviating feelings of stress, helplessness, associated with illness, thereby reinforcing the belief in the feasibility of recovery and enhancing patient motivation to participate in the recovery process **(El-Monshed & Amr, 2020)**.

Recovery is a process of incremental, significant actions

marked by an evolving feeling of autonomy, agency, and integrity that transcends the constraints of the handicap (**Murwasuminar, Munro, & Recoche . 2023)**. The principles of recovery for patients with psychiatric disorders emphasize maintaining control over their lives rather than merely reverting to pre-illness functioning **(Sreeram, Cross, & Townsin, . 2023)**. This approach prioritizes resilience and management of challenges, alongside leading a meaningful life, which is the primary objective for many patients. It contradicts conventional notions of mental disease and societal attitudes, which often put constraints on individuals with psychiatric problems **(Dubreucq et al. 2022)**.

Mental health recovery encompasses five fundamental domains: **clinical** (e.g., symptoms), **physical** (e.g., exercise), **functional** (e.g., employment), **existential** (e.g., self-determination), and **social** (e.g., social support) **(Bjørlykhaug, Karlsson, Hesook & Kleppe., 2022)**. The impact of perceived social support on the recovery of psychiatric patients has been the subject of research globally. It is founded as a fundamental source of psychological well-being **(Carr & Ponce, 2022)**.

Furthermore, social support facilitates patients with psychiatric disorders in seeking timely treatment for their mental health issues , improving symptoms, preventing relapse, fostering healthy relationships, achieving independence, recognizing their skills and limitations, exercising self-control and self-regulation, and improving overall life satisfaction and quality of life **(Hamza, Berma, & El-said,. 2022)**. Conversely, individuals with psychiatric diseases and inadequate assistance face heightened risks of social isolation, loneliness, symptom exacerbation, relapse, and suicide. Given these benefits of social support, enhancing social support should be a primary objective for those with psychiatric disorders. To ensure that people, families, and communities possess qualities and resources that underpin recovery **(Ishikawa, Rickwood, Bariola & Bhullar., 2023)**.

Significance of the study:

Psychiatric diseases impose a significant strain on people, families, society, and communities. It adversely impacts quality of life, medical expenses, health outcomes, consumption of health resources, and patient death rates **(Caple, Maude, Walter & Ross,. 2023)**. The adverse consequences are closely associated with insufficient

social support, leading to inadequate healing and rehabilitation of psychiatric diseases. Social support has a crucial role in treatment progression, symptoms improvement, relapse prevention, medication adherence, and enhancing patients' quality of life by providing feelings of safety, security, empathy, self-esteem, and self-worth **(Ebrahim, El-Bilsha & Elhadidy ., 2021).**

Patients with robust social support exhibit enhanced recovery and functioning. Recovery is a dynamic process characterized by advancement towards states of optimism and significance. Engagement in a significant social life may be a major objective for several Patients in recovery. Psychiatric health nurses may restore social support and send patients for further assistance via social experts and community resources **(El-Monshed & Amr, 2020).**This i is crucial for enhancing recovery.

Aim of the Study

Assess the association between perceived social support and recovery among patients with psychiatric disorders.

Research Questions

1. What are the levels of perceived social support among patients with psychiatric disorders?

2. What are the levels of recovery among patients with psychiatric disorders?

3. What is the association between perceived social support and recovery among patients with psychiatric disorders?

Subjects and Methods

Research Design

The present study used a descriptive correlational research approach.

Setting: The outpatient clinic of Psychiatry, Neurology and Neurosurgery Center and Psychiatric Tanta University Hospital was the setting of this study. Both settings are affiliated by Tanta University, Ministry of Higher Education and Scientific Research which provide services of screening new Cases, follow up and providing psychotropic medication.

Subjects

A convenience sample of 260 patients diagnosed with psychiatric disorders. The sample size and analytical power were computed using the Epi-Info software statistical tool. The subjects were chosen from the prior setting based on the following criteria.

Inclusion criteria

- Age: 18 years and more.
- Patients diagnosed with psychiatric disorders.
- Patients are willing to participate in the study.

Exclusion criteria:

- Patients diagnosed with mental retardation, or substance use disorder.

Tools for data collection

The data was collected by using the following two tools:

Tool I: Multidimensional Perceive Social Support Scale (MSPSS):

It consists of two parts:

Part I: Patient's socio-demographic data and clinical characteristics: It was developed by the researcher based on reviewing of related literature, include:

Socio-demographic characteristics of patients includes: patient's age, sex, marital status, and level of education, place of residence, occupation, income and living status.

Clinical characteristics of patients includes: age of onset of illness, duration of illness, number of previous psychiatric hospitalization, and clinical diagnosis.

Part II: Multidimensional Perceived Social Support Scale (MSPSS): It was created by **(Zimet, Dahlem, Zimet & Farley,. 1988)**, and was adopted by the researcher. Its purpose was to gauge how people perceived social support. The scale consists of 12 elements are broken down into three subscales: friends (4 things), family (4 items), and significant other (4 items). Every

item is scored on a 7-point Likert scale, with 1 denoting "very strongly disagree" and 7 denoting "very strongly agree."

Scoring system

Mean scale score ranging from 1 to 2.9 could be considered low support, a score of 3 to 5 could be considered moderate support and a score from 5.1 to 7 could be considered high support.

Tool II: The Recovery Assessment Scale Revised (RAS-R): It was developed by **(Giffort, Rashid, Leary & Okeke., 1999)**, and was adopted by the researcher. The most used scale for assessing mental health recovery is this one. The 24 items on the scale are broken down into 5 subscales: 3 items on being willing to seek for help; 5 items on goal and success orientation; 4 items on relying on others; 9 things on personal confidence and hope; and 3 items on not being dominated by symptoms. Every item is scored on a five-point Likert scale, with 1 denoting "strongly disagree" and 5 denoting "strongly agree.

Scoring system

- More than 70% High level of mental health recovery.
- 50-70% Moderate level of mental health recovery.
- Less than 50% Low level of mental health recovery.

Methods

1 - An official letter was sent by the dean of the nursing faculty to the director of the study settings, requesting their assistance and consent for data collection.

2- Official approval from the Scientific Research and Ethical Committee of the Faculty of Nursing was obtained with code No (**4011-3-2024**).

- Informed consent was obtained from the patient after explanation the purpose of the study to obtain his acceptance, cooperation.

- The study's nature did not inflict any harm or pain on the subjects involved.

- The participants were assured of the confidentiality and privacy of their collected information.

- Participants have the right to withdraw at any point during the data collection period.

3- The researcher translated the study tool into Arabic and assessed its internal validity with the input of five experts in the field of psychiatric nursing, making necessary modifications based on their revisions

4- The suitable statistical test analysis was used for testing the reliability of all tools using Cronbach's alpha test. Cronbach's alpha values were 0.861 for total multi-dimensional perceived social support scale 0.772 for total recovery assessment scale revised.

5- A pilot study was conducted on 10% of the sample to evaluate the feasibility and applicability of the tools.

6. The actual study

- The records of the patients were reviewed, and the subjects for the study were selected based on the established inclusion criteria.

- The study's purpose was explained to the patients, who were then invited to participate.

- Data was collected through face-to-face interviews with each patient on an individual basis.

- The researcher met the patients within range of three to four days per week on the individual basis. The time of interviewing with patient ranged from 45 to 60 minutes according to patient's condition and tolerability to answer the questions.

- The duration of data collection was six months starting from July2024 to the end of December 2024.

Statistical analysis

The collected data underwent systematic organization, tabulation, and statistical analysis using SPSS version 23. For quantitative data, the mean, standard deviation, and range were calculated. Categorical data were summarized using numbers and percentages. The chi-square test ($\chi2$) was used for comparisons. To

evaluate the relationships between variables, Pearson's correlation coefficient (r) was empolyed. A significance threshold of P<0.05 was used to determine statistical significance (*), and a further level of significance at P<0.01 was also considered (**).

Results

Table (1) shows that, more than half of the studied patients (58.5%) were female. Concerning age nearly three quarter of the studied patients (72.3%) aged more than 40 years old with Mean ± SD 46.31± 8.425. Regarding marital status two fifth of the studied patients (38.1%) were divorced. It was founded that more than half of the studied patients (54.6%) had university education while minority of them were illiterate (5.4%). In relation to residence about half of the studied patients (50.4%) lived in rural areas and the rest of them live in urban areas. As regarding occupational status (59.6%) of the studied patients were employees. In relation to income, (76.5%) of the studied patients had not enough income. Concerning living status about three quarter of the studied patients (75.8%) were living with their family.

Table (2) represents that, more than half of the studied patients (55.8%) experienced the onset of their illness at age more than 20 years old with Mean ± SD26.38±4.247. Concerning duration of illness, the majority (83.5%) of the studied patients had disease more than 7 years old with Mean ± SD 17.90± 9. 564. Regarding the number of previous hospitalization about one third of the studied patients (34.2%) were admitted three times and more than three-time. In relation to diagnosis, (40.8%) of the studied patients had major depressive disorder.

Table (3): **Clarifies**, that total Mean ± SD of perceived social support scale was (52.03±18.306). It presents that there is highly statistically significant relation among total perceived social support scale and its subscales in which (P-value =0.000).

Figure (1): Clarifies that, about half of the studied patients (48%) had high level of total perceived social support and nearly one third of the studied patients (29 %) had moderate level of total perceived social support while (23%) of them had low level of total perceived social support.

Table (4): Shows that, recovery assessment: the total Mean ± SD of **recovery** assessment scale was (77.33±24.495). It presents that there is highly statistically significant relation among total recovery

assessment scale and its subscales in which (P-value =0.000).

Figure (2): Illustrates that, about half (48%) of the studied patients had high level of total recovery and (18%) of the studied patients had moderate level of total recovery while, more than one third (34%) of them had low level of total recovery.

Table (5): indicates a high statistically significant positive correlation among total perceived social support and total mental health recovery (r=.876**, p=000). This means higher levels of perceived social support is associated with higher levels of mental health recovery.

Table (1): Distribution of the studied patients according to their sociodemographic data.

Socio-Demographic characteristics	Number of the studied patients=260	%
Age		
Less than 30	11	4.2
From 30 to 40	61	23.5
More than 40	188	**72.3**
Mean ± SD	46.31± 8.425	
Range	(66-20)	
Sex		
Male	108	41.5
Female	152	**58.5**
Marital status		
Single	78	30.0
Married	40	15.4
Divorced /Separated	99	**38.1**
Widow	43	16.5
Residence		
Rural	131	**50.4**
Urban	129	49.6
Occupation		
Work	155	**59.6**
Not Work	105	40.4
Educational Level		
Illiterate	14	5.4
Read & write	26	10.0
Secondary Edu	78	30.0
University Degree	142	**54.6**
Income		
Enough	61	23.5
Not enough	199	**76.5**
(Cohabitation)		
Alone	63	24.2
With Family	197	**75.8**

Table (2): Distributions of the studied patients according to their clinical characteristics.

| Clinical characteristics	Number =(260)	%
Age of onset of illness		
≤20	19	7.3
>20-25	96	36.9
>25	145	**55.8**
Mean ± SD	**26.38±4.247**	
Range	**(35-17)**	
Duration of illness		
<5 years	19	7.3
5-7 years	24	9.2
>7 years	217	**83.5**
Mean ± SD	**17.90± 9.564**	
Range	**(20-1)**	
Number of previous psychiatric hospitalization		
Not admitted previously	35	13.5
Once	69	26.5
Twice	67	25.8
≥Three time	89	**34.2**
Diagnosis		
Major Depressive Disorder	106	**40.8**
Schizophrenia	61	23.4
Bipolar	54	20.8
Anxiety	39	15.0

Table (3): Mean score of the multi-dimensional perceived social support scale (MSPSS) subdomains.

Multi-dimensional perceived social support scale (MSPSS) Subdomains		Mean ± SD	χ^2 p
	Significant other	17.60±6.836	280.5 0.000
	Family	17.53±6.560	
	Friends	16.90±6.804	
	Total (MSPSS)	52.03±18.306	
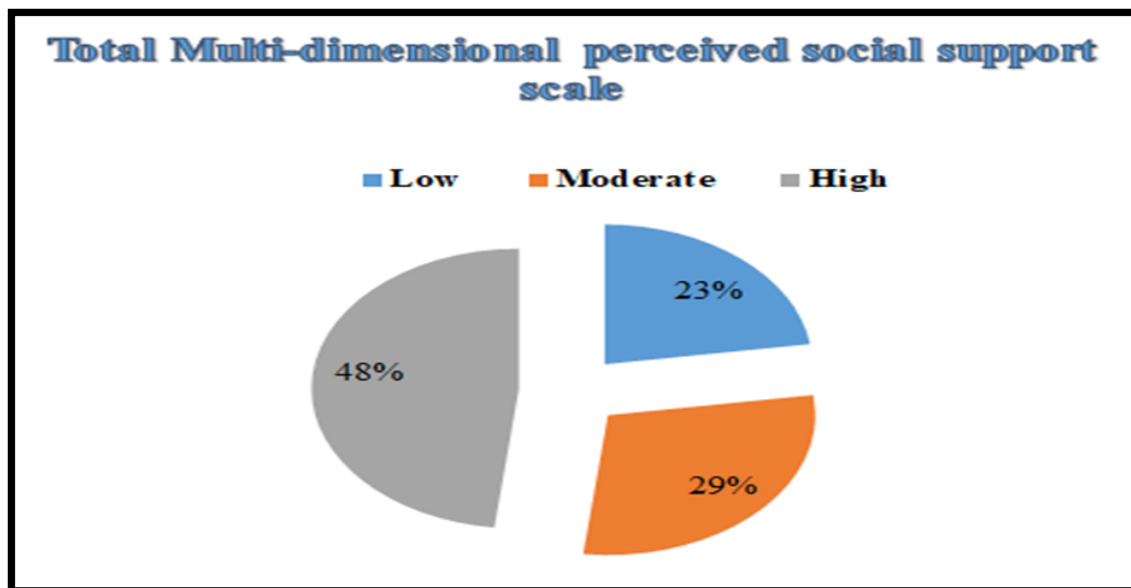
Figure (1): Distributions of the studied patients according to total multi-dimensional perceived social support scale (MSPSS).

Figure (2): Distributions of the studied patients according to their total levels of recovery assessment scale revised (RAS-R)
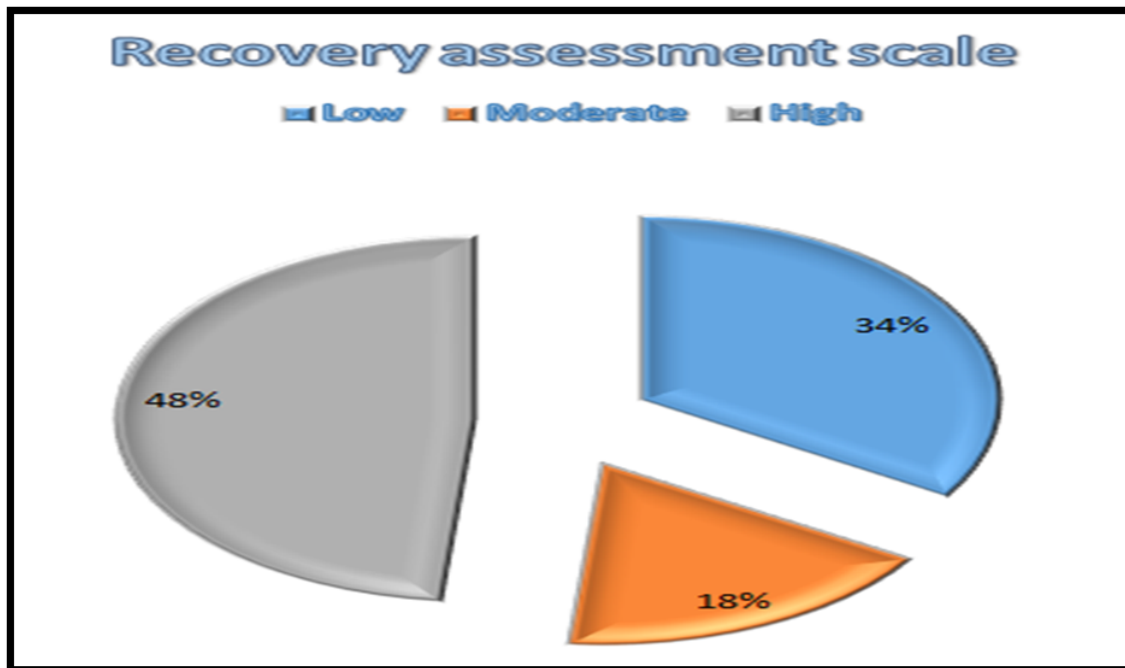
Table (4): Mean score of the recovery assessment scale revised (RAS-R) subdomains.

		Mean ± SD	χ^2 p
Recovery assessment scale revised (RAS-R) Subdomains	**Willing to Ask Help**	**9.49±3.429**	**170 0.000**
	Goal& Success Orientation	**16.24±5.593**	
	Reliance on others	**13.55±4.764**	
	Personal Confidence	**28.15±10.189**	
	Not dominated by symptoms	**9.90±3.351**	
	Total (RAS-R)	**77.33±24.495**	

Table (5): Correlation among recovery assessment scale revised and multi-dimensional perceived social support scale

Items			Total Multi-dimensional perceived social support scale		Total recovery assessment scale revised	
			r	p	r	p
Multi-dimensional perceived social support scale Subdomains		**Significant other**	.888**	0.000	.823**	0.000
		Family	.909**	0.000	.778**	0.000
		Friends	.922**	0.000	.781**	0.000
Recovery assessment scale revised Subdomains		**Willing to Ask Help**	.787**	0.000	.869**	0.000
		Goal& Success Orientation	.822**	0.000	.896**	0.000
		Reliance on others	.861**	0.000	.923**	0.000
		Personal Confidence	.734**	0.000	.897**	0.000
		Not dominated by symptoms	.772**	0.000	.885**	0.000
Total recovery assessment scale			.876**	0.000	------	-------

** Correlation is significant at the 0.01 level.

*. Correlation is significant at the 0.05 level.

r: Pearson correlation coefficient P<0.05 P interpretation for r Absent = 0 Weak (0.1 : <0.25) Intermediate (0.25 : < 0.75) Strong (0.75 : <1) Perfect = 1.

Discussion

Social support is essential for treatment progress, symptom improvement, relapse prevention, medication adherence, and improving patients' quality of life as; it increases feelings of safety, security, empathy, self-esteem, and self-worth, as well as fostering healthy relationships that aid in the healing process **(Khan & Sultan, 2023)**.

According to the current study's findings, around half of the studied

patients reported a high level of social support. There are a number of reasons for this, including robust networks of friends and family. This is most likely because of the strong familial ties in the Middle East, where a large number of people with Psychiatric illnesses either live with their families or have regular contact with their parents, spouses, siblings, and children.

This actually corroborated by the current study's findings, which showed that the majority of the studied patients had family support and that the majority of those living with their relatives had high levels of perceived support. This study is consistent with the Egyptian study carried by **Acoba, (2024)**. Who founded social support was highly valued among studied patients. The current finding contrast with A study of **Farouk & Berma (2024)** which found that most psychiatric patients had low levels of social support.

Regarding to recovery among patients with psychiatric disorders, the current study revealed that roughly half of the studied patients had a high level of recovery. This could be explained by a number of factors, including the fact that over half of the studied patients were employed, which enhances recovery outcomes by fostering a sense of independence and self-realization.

This explanation supported with that the primary domain of recovery in this study was personal confidence, as half of the patients reported high levels of personal confidence during data collection.

Furthermore, the majority of the studied patients in the study were educated, and education is frequently associated with improved access to information and a better understanding of mental health conditions, symptoms, and available treatments. The current study's findings are agreement with **El-Monshed & Amr's (2020)** study, which found that patients with schizophrenia had a high degree of recovery. This result was in contrast to the study conducted by **Farouk& Berma, (2024)** found that patients with psychiatric disorders had a low level of recovery.

The current study's findings showed a highly positive statistically significant correlation between perceived social support and recovery, which can be explained by social support helps identify psychiatric disorders early by fostering close, supportive relationships that help identify any psychological changes and encourage them seek professional help early.

social support helps patients respond better, control symptoms, adhere to

treatment plans, Through, helping patients feel valued, secure, and connected to others, as well as by helping them accept the limitations and disabilities imposed by illness, which speeds up the healing process. This present result was actually in the line of a study conducted in Egypt by **Hamza et al. (2022)** found a positive statistical correlation between recovery and perceived social support among patients with psychiatric disorders.

Conclusions

According to the study finding it was concluded that social support has critical role in promoting patients' recovery, therefore, it ought to be a fundamental component of psychiatric treatment.

Recommendations: The following recommendations were made in light of the current study's findings:

Recommendations for psychiatric patients

-Implementing social support educational programs for patients with psychiatric disorders should be considered as essential element of recovery.

Recommendations for mental health nurses and hospitals:

- Encouraging nurses regularly to follow recent researches about the role of social support in improving recovery of patients with psychiatric disorders.

- Provide educational training course that teaches nurses how provide social support for patients and their families.

Recommendations for the community and families

- Public health awareness programs should be planned and implemented to teach people about strategies to improve social support. These programs should be accessible to people in schools, universities, social groups, religious institutions, and the media. (not applicable))

- Initiatives to teach caregivers about their supportive role toward patient.

- Programs to help family of patients with psychiatric disorders better grasp the nature of psychiatric disease and provide more care for their loved ones are desperately needed.

4) **Future research**

-More research is required to evaluate additional factors influencing the recovery of people with psychiatric disordeders

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