Relationship between Social Support and the Quality of Life Among Psychiatric Patients

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ABSTRACT

Background: Mental health disorders are medical conditions that influence individuals' daily functioning, ability to maintain social relationships, and decrease their quality of life (QOL). Social support is meaningful because it is essential for mental health as well as enhancing psychiatric patients' QOL. **Aim** This study was to assess the relationship between social support and QOL among psychiatric patients. **Subjects and Method** A descriptive correlational research design is utilized for the current study. The study subjects are a convenience sample of 115 patients from five psychiatric inpatient units and one outpatient clinic of Port-Said Mental Health Hospital. Three structured interview schedules were utilized to collect the necessary data: Tool I: WHO Quality of Life Scale Bref version، Tool II: The Multidimensional Scale of Perceived Social Support, in addition to a socio demographic and clinical data questionnaire. **Results** The study revealed that more than half of the psychiatric patients reported low QOL and two thirds of them reported low social support. In addition, there was a statistically significant positive correlation between social support and QOL. It was observed that disease onset, onset of treatment, and previous hospitalization significantly affect the social support level. But, the age, income, employment status, diagnosis, and disease onset significantly affects the QOL. **Conclusion and Recommendation** It can be concluded that most of psychiatric patients have low social support and QOL. In addition, there is a relation between social support and QOL. Therefore, social support should be an essential part of psychiatric treatment because of its important role in enhancing patients' QOL. The study recommended increasing the awareness of the mental health team about the importance of dealing holistically with psychiatric patients as considering his/her physical, psychological, social, and environmental aspects.

Keywords: psychiatric illness, Quality of Life and Social support.

INTRODUCTION

Mental illness can have devastating effects on the individual and his/her family. Mentally ill patients can experience loss of support from family, friends or partners, resulting in small or restricted social support resources predominately consist of family members or mental health professionals. Small social support networks have been associated with isolation and depression. It also threats psychological and emotional well-being, quality of life (QOL), and increases the likelihood of psychiatric re-hospitalization. Individuals living with mental illness experience functional impairments in daily living skills and social skills. These impairments can negatively affect social opportunities ***(Pernice-Duca, 2005)***.

Human beings are social by nature and rely on each other not only for survival but also for intimacy, support, knowledge, understanding and guidance. The longing for interpersonal intimacy stays with every human being from infancy throughout life. Most human life in a matrix of relationships that define their identity (I am a daughter, wife, mother, student, etc.) and their personality (I am extroverted, friendly, and kind) ***(Osman, 2014)***.

Social support is a term that does not have a widely agreed-upon definition in the development literature because it is a multidimensionality construct (Hernandez, 2012). Social support is generally defined as a range of interpersonal relationships or connections that have an impact on the individual's functioning ***(Barker, 2007)***. Another definition of social support is "individuals' perceptions of general support or specific supportive behaviors (available or enacted) from people in their social network, which enhances their functioning and buffer them from adverse outcomes of stress" ***(Malecki and Demaray, 2002)***.

Positive social relationships may be associated with happiness and well-being. Inclusion in a social network may provide a source of generalized positive affect and this positive psychological state may contribute to overall health and leads to better QOL ***(Pasmeny, 2009)***. Quality Of Life is defined as "a measure of individuals' ability to function physically, emotionally and socially within their environment at a level consistent with their own expectations" ***(Barcaccia, Esposito, Matarese, Bertolaso, Elvira, and De Marinis, 2013).***

Patients with severe mental illness experience a lower QOL than general population. They have high unemployment rates, live in substandard housing or are homeless, and have few social supports ***(Evans, Banerjee, Leese, and Huxley, 2007)***. QOL is a person's sense of well-being, health status and satisfaction with life circumstances, including access to resources and opportunities **(*Medici, Vestergaard, Hjorth, Hansen, Shanmuganathan, Viuff, and Jørgensen, 2016)***.

Significance of this study:

Mentally ill patients found difficulty in social support and QOL. So, one of the psychiatric nursing objectives is to improve psychiatric patients' QOL through

enhancing social support provided to the patient. In order to do this the nurse should first assess patients' QOL and social support, identify the problems within social support and spheres of physical, psychological, social and environmental aspects to assist the patient in achieving their maximum possible functions as well as expanding their social relationships.

AIM OF STUDY:

The aim of this study is to assess the relationship between social support and quality of life among psychiatric patients.

Objectives of the present study to:

1. Assess social support of psychiatric patients in Port Said Psychiatric Health Hospital.
2. Assess quality of life of psychiatric patients in Port Said Psychiatric Health Hospital.
3. Identify factors affecting QOL for these patients.
4. Find the relationship between social support and quality of life.

SUBJECTS AND METHOD:

Research design

A descriptive correlational research design was followed in this study.

Study setting

The present study was carried out at Port Said Psychiatric Health Hospital that affiliated to the Ministry of Health. The hospital is composed of eight departments: five inpatient psychiatric units (three units for male patients and two units for female patients). One ward for drug dependents, one outpatient clinic, and one child unit.

Study subjects

The total sample size amounted to 118 patients. While 115 psychotic patients attending the psychiatric outpatient clinic and five inpatient units in the previously mentioned hospital were collected by, a convenience sample and three patients dropped out during data collection.

Sample size

To achieve the study objective, the sample size is determined by using the following equation. The sample size is determined by using the following equation ***(Naing, 2003)***:

Sample size (n) = $(z/\Delta)^2 p (1-p)$.

Where:

P: The prevalence of conventional of (The impact of social support on the quality of life among psychiatric patients) = 8 % ***(Yasien, Alvi, Moghal, 2013)***.

$Z\alpha/2$: a percentile of standard normal distribution determined by confidence level = 1.96

Δ: The width of confidence interval = 5%

(Sample Size (n) = 113 patients)

The sample size is 113 patients, due to the expected drop out rate (5%); the final sample size is =118 patients.

Tools of data collection:

Tool I: ***WHO Quality of Life Scale (Bref version) (WHOQOL – Bref)***

The WHOQOL – Bref developed by ***World Health Organization (1998)*** and translated into Arabic by ***Ahmed (2008)***. The scale has 26-items that measure the following broad domains: physical domain (7 items), psychological domain (6 items), social relationships domain (3 items), and environmental domain (8 items), general health and overall QOL (2 items). The 26 items have only three negative questions and the remaining 23 questions are positive questions. The score ranges of 1(Not at all), 2 (Not much), 3 (Moderately), 4 (Mostly), and 5 (Completely). A critical value (i.e. 60%) is indicated as the optimal cut-off point for assessing QOL. The patient's QOL was considered high if the percentage was 60% or more and low if less than 60% (***Silva, Soares, Santos, and Silva, 2014)***.

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

This questionnaire was developed by ***Zimet, Dahlem, Zimet, and Farley (1988)***, and translated by ***Abou Hashem (2010)***. It is a 12-item instrument designed to assess perceptions of social support from three specific sources: family, friends and significant other. The scale is rated on a 5 – likert scale with a range from strongly disagree = 1, to strongly agree = 5. A critical value 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%.

In addition, socio-demographic and clinical characteristic questionnaire, this was developed by the researcher after review of literature. It included socio demographic data such as patient's age, gender, marital status, educational level, current employment status, family income, number of family members. As regarding clinical characteristics, these included outpatient clinic or inpatient units, clinical diagnosis, onset of disease, duration of illness.

Pilot study:

Before entering the actual study, a pilot study was carried out on 10 % of the total sample of the hospitalized mentally ill patients and was conducted from 1/1/2015 to 4/2/2015. They were excluded from the entire sample of research work. The pilot study was done to ascertain clarity, feasibility, and applicability of the study tools, to estimate the proper time required for answering the questionnaire, and to identify obstacles that may be faced during data collection.

Method of data collection:

- The 115 patients were selected from the previous setting according to the previous criteria. (115 patients complete the interview and three of them refuse to complete after completing the half of the sheets).

- The tools were filled by the researcher using the interview method on an individual basis.

- Each interview lasted about 60 to 90 minutes according to the patient's attention, concentration, and willing to cooperate or talk.

- A number of 2-5 patients were interviewed per day.

- Patients' clinical data were checked from their medical charts to be implemented in the tools.

- Data were collected over a period of six months starting from first of June and ending December 2015 (Two days per week (Saturday and Tuesday) from 9 a.m. to 2 p.m.).

Administrative design:
Before the study carried out, an official letter was addressed from the Dean of the Faculty of Nursing to the Director of the identified study setting, requesting his cooperation and permission to conduct the study after explaining the aim of the study.

Ethical Considerations:
A written consent was taken from patients and delivered to the hospital, after explaining the purpose and the importance of the research study. Patients assured about the confidentiality of the information gathered and that it will be used only for the purpose of the study.

Statistical Design:

Data were collected, organized, tabulated and statistically analyzed with SPSS 18.0 software computer statistical. Data were presented using descriptive statistics in the form of frequencies and percentages for qualitative variables, means and standard deviations for quantitative variables. Qualitative categorical variables were compared using chi-square test. In larger than 2x2 cross-tables, no test could be applied whenever the expected value in 10% or more of the cells was less than 5. Person correlation analysis was used for assessment of the inter-relationships among quantities variables. Statistical significance was considered at P-value <0.05.

RESULTS:

Table (1): reveals that patients' age ranges between 20 and 65 years old with a mean age ± SD of 34.1±12.0 years; the age of more than half of them (i.e.53.9%) ranges between 20 and 35 years old; 61.7% were males; and 59.1% of them were single; and40% of them have secondary education, whereas, only 14.0% of patients are illiterate. More than three quarters (87.8%) of the studied patients were unemployed. Whereas, 80% of them were employed as a manual worker, compared to 20.0% were employees, 55.7% have enough income, and only 4.3% of them living alone.

Table (2): presents that about two thirds of studied patients (65.2%) admitted to inpatient ward, 62.7% of them admitted to free departments, more than half of them are schizophrenic (56.5%), while 25.2% have bipolar disorders. The studied patients have a mean disease onset 6.2 $\pm$ 5.3 years and about 53.0% have been ill for one year. Only 20%

of the studied patients had no previous history of hospitalization, while the majority of them (80.0%) were previously hospitalized.

Table (3): illustrates that the majority of the studied patients (80.9%) have a low score in social domain, almost two thirds of them (67.8%) have also a low score of environmental domain, and 67.0 % of them had also a low score of psychological domain. But, 40.9% of them had high score toward physical domain. Three quarters of the studied patients (75.7%) had a low QOL, with a mean of 47.3±18.5. The studied patients perceive highly social support from significant others, followed by from family (60% and 51.3% respectively), while, most of studied patients perceived a low social support from friends (73%). More than half of patients (60%) have a low social support, with a mean of 52.1±23.8.

Table (4): shows statistically significant positive correlations between total of QOL in relation to social support from significant others, from family and from friends (r=0.741, 0.643, and 0.568). In addition, there is positive correlation between total score of QOL and total score of social support (r=0.743).

Table (5): illustrates that high social support level is statistically significant among patients in inpatient department as **P<0.0001**,while, low social support level was statistically significant among patients who had disease from one year to less than five years **P=0.018**. Furthermore, high social support level was statistically significant among patients who started treatment from one year to less than five years and have previous hospitalization as ^{MC}**P<0.0001**.

Table (6): illustrates that 59.5% of schizophrenic patients have the lowest level of quality of life compared to other patients. Moreover low level of QOL was statistically significant among schizophrenic patients as **MCP=0004**.

Table (1): Socio-demographic characteristics of the studied patients.

Socio-demographic Characteristics	Studied patients (n=115)	
	No.	**%**
Gender		
Male	71	61.7
Female	44	38.3
Age (years)		
20-<35	62	53.9
35-<50	35	30.4
50-65	18	15.7
Min-Max, Mean ±SD	**20-60**	**34.1±12.0**
Marital Status		
Single	68	59.1
Married	25	21.8
Divorced/ Widow	22	19.1
Educational Level		
Illiterate/ Read and write	16	14.0
Basic education	39	33.9
Secondary education	46	40.0
University education or higher	14	12.1
Current Employment Status	14	12.2
Employed	101	87.8
Unemployed		
Type of Current Work (n=14)		
Manual worker*	10	80
Employee*	4	20
Family Income/Month		
Enough	64	55.7
Not enough	51	44.3
Number of Family Members		
1-3	53	46
4-6	54	47.0
7 or more	8	7.0
Min-Max, Mean ±SD	**1-10**	**3.7±1.7**

**** Employee*** *(Teacher, social worker, administrative)*

**** Manual worker*** *(Electrician, driver, machinist)*

Table (2): Clinical characteristics of the studied psychiatric patients.

Clinical Characteristics	Studied patients (n=115)	
	No.	**%**
Department		
Outpatient clinic	40	34.8
Inpatient	75	65.2
Diagnosis		
Schizophrenia	65	56.5
Bipolar disorder	29	25.2
Depression	8	7.0
Drug induced psychosis	9	7.8
Schizoaffective disorder	4	3.5
Disease Onset (years)		
1-<5	61	53.0
5-<10	23	20.0
10-<15	18	15.7
15-20	13	11.3
Min-Max, Mean ±SD	**1-20**	**6.2±5.3**
Onset of Treatment (years)		
Not started treatment yet	18	15.7
1-<5	54	47.0
5-<10	15	13.0
10-<15	16	13.9
15-20	12	10.4
Min-Max, Mean ±SD	**0-20**	**5.4±5.5**
Pervious Hospitalization		
Yes	92	80
No	23	20

Table (3): Total quality of life and social support among the studied patients.

Item	Min-Max	Mean ± SD	Score (%)			
			Low (<60%)		High (60%≤)	
			No.	%	No.	%
Quality of life						
Physical domain	10.7-96.4	53.3±16.6	68	59.1	47	40.9
Psychological domain	4.2-100.0	48.9±20.1	77	67.0	38	33.0
Social relationship domain	0.0-100.0	36.2±25.2	93	80.9	22	19.1
Environmental domain	0.0-93.8	50.7±19.1	78	67.8	37	32.2
Total quality of life	**3.7-87.1**	**47.3±18.5**	**87**	**75.7**	**28**	**24.3**
Perceived Social Support						
Social support from significant others	20.0-100.0	61.0±28.3	46	40.0	69	60.0
Social support from family	20.0-100.0	55.7±26.5	56	48.7	59	51.3
Social support from friends	20.0-100.0	39.6±26.5	84	73.0	31	27.0
Total Social Support	**20.0-100.0**	**52.1±23.8**	**69**	**60.0**	**46**	**40.0**

Table (4): Correlation between total quality of life and social support level among the studied patients**.**

Social Support Subcomponents	Total quality of life	
	r	P
Social support from significant other	0.741	<0.0001*
Social support from family	0.643	<0.0001*
Social support from friends	0.568	<0.0001*
Total Score	**0.743**	**<0.0001***

r: Pearson correlation coefficient ***significant at P≤0.05**

Table (5): Relation between social support level and clinical characteristics of the studied patients (n =115).

Clinical Characteristics	Social Support Level				Significance
	Low (<60%) [n=69]		High (60%≤) [n=46]		
	No.	%	No.	%	
Department					
Outpatient clinic	33	47.8	7	15.2	**X^2=17.619**
Inpatient department	36	52.1	39	84.8	**P<0.0001***
Diagnosis					
Schizophrenia	38	55.1	27	58.7	X^2=6.558
Bipolar disorder	15	21.7	14	30.5	^{MC}P=0.162
Depression	8	11.6	0	0.0	
Drug induced psychosis	6	8.7	3	6.5	
Schizoaffective disorder	2	2.9	2	4.3	
Disease Onset (years)					
1-<5	39	56.5	22	47.8	**X^2=10.032**
5-<10	18	26.1	5	10.9	**P=0.018***
10-<15	8	11.6	10	21.7	
15-20	4	5.8	9	19.6	
Onset of Treatment (years)					
Not started treatment yet	18	26.1	0	0.0	**X^2=20.795**
1-<5	29	42.0	25	54.3	**^{MC}P<0.0001***
5-<10	11	15.9	4	8.7	
10-<15	8	11.6	8	17.4	
15-20	3	4.3	9	19.6	
Pervious Hospitalization					
No	22	31.9	1	2.2	**X^2=15.226**
Yes	47	68.1	45	97.8	**^{MC}P<0.0001***

X^2: Chi-Square test ^{MC}P: Monte Carlo corrected P-value *significant at P≤0.05

Table (6): Relation between total quality of life and clinical characteristics of the studied patients (n =115).

Clinical Characteristics	Total quality of life				Significance
	Low (<60%) [n=87]		High (60%≤) [n=28]		
	No.	%	No.	%	
Department					
Outpatient clinic	33	37.9	7	25.0	X^2=3.005
Inpatients units	54	62.1	21	75.0	P=0.223
Diagnosis					
Schizophrenia	52	59.8	13	46.4	
Bipolar disorder	15	17.2	14	50.0	**X^2=15.154**
Depression	8	9.2	0	0.0	**^{MC}P=0004***
Drug induced psychosis	9	10.4	0	0.0	
Schizoaffective disorder	3	3.4	1	3.6	
Disease Onset (years)					
1-<5	44	50.6	17	60.7	
5-<10	21	24.1	2	7.1	X^2=4.92
10-<15	14	16.1	4	14.3	^{MC}P=0.184
15-20	8	9.2	5	17.9	
Onset of Treatment (years)					
Not started treatment yet	16	18.4	2	7.1	
1-<5	38	43.7	16	57.1	X^2=5.744
5-<10	13	14.9	2	7.1	^{MC}P=0.215
10-<15	13	14.9	3	10.7	
15-20	7	8.0	5	17.9	
Previous Hospitalization					
No	20	23.0	3	10.7	X^2=1.995
Yes	67	77.0	25	89.3	P=0.158

X^2: Chi-Square test ^{MC}P: Monte Carlo corrected P-value *significant at P≤0.05

DISCUSSION:

Psychotic disorders are often chronic, lifelong illnesses that have a major impact on the individual, family, and community resources ***(Capleton, 2000)***. People with mental illness struggle with poor QOL and social support; they often cannot develop or sustain supportive relationships within their lives ***(Mordoch, 2005)***.

Social support is widely recognized as a crucial factor for mental health and wellbeing ***(Ng, Nurasikin, Loh, Anne Yee, and Zainal, 2012)***. It is one of the most effective means by which people can cope with and adjust to difficult and stressful events **(Kim, *Sherman*, and Taylor, 2008)** and has a positive effect on the process and outcome of psychotherapy and psychiatric treatment ***(Brüggemann, Garlipp, Haltenhof, and Seidler, 2007)***. Therefore, the present study aimed to explore the impact of social support on the quality of life in psychiatric patients.

The finding of the present study denoted that most of the study subjects had a low QOL almost on all dimensions as well as on the total score. This may be because of the impact of psychiatric disorder is understandable considering the many dimensions of QOL that these disorders influence. This result was supported by ***Langeland, Wahl, Kristoffersen, Nortvedt and Hanestad (2007),*** who studied QOL among Norwegians with chronic mental health problems versus the general population and found that they scored substantially lower than the general population in QOL total score and its sub- dimensions.

The present study revealed that most of patients had a low score in many areas especially the social domain and environmental domain as well as psychological domain. This might be interpreted by that, mentally ill patients have fewer social and cognitive skills, and fewer environmental assets, especially money. Similar findings were reported from China, as ***Young (2012***), studied QOL of people with severe mental illness and found that respondents were least satisfied with their social, environmental, and psychological domains.

The results of the present study also indicated that the physical domain was the highest domain that psychiatric patients had; this may be due to that, mental illness affects cognitive, affective, and behavioral status of patients rather than their physical status. This result was supported by a study conducted in England, as ***Blenkirson and Hammille (2003*)** studied patients' satisfaction with their mental health care and QOL and stated that the highest domain that psychiatric patients had was the physical domain. In contrast to that, ***Nyboe and Lund (2012),*** who examined physical activity in people with mental health conditions in Denmark and demonstrated that, patients with severe mental illness had very low physical activity level.

The results of this study revealed that the highest social support perceived by studied patients was from significant others. This may be due to the fact that, significant others may include any special person in the patient's life such as a boyfriend /girlfriend, a doctor, a nurse or a clerk and support psychiatric patients more than their family members. A Boland study by ***Bronowski and Załuska (2008*)** supported this result as they studied social support of chronically mentally ill patients and reported that therapists were the most numerous group who provided support and close relatives come second.

The present study found that the studied patients secondly perceived social support from their families. This is probably 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 ***Goldberg, Rollins and Lehman (2003)*** in United States. They studied social network among

people with psychiatric disabilities and found that the subjects mentioned their closest relatives as the most frequently used supporters. In addition, ***Brunt and Hansson (2002*)**, who studied social networks of persons with severe mental illness in in-patient settings and supported community settings in Sweden, found that patients had a higher proportion of family members in their social networks.

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. It is a disgrace being a mentally ill patient, or associated to someone who is. This result contradicted with ***Sharir (2005)*** in United States. ***Sharir*** studied social support and QOL among psychiatric patients in residential homes and found that social support from friends had a higher mean than the other two sub-components of social support from family and social support from a significant other.

In relation to total social support level, the present study revealed that more than half 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. This result was consistent with ***Brunt and Hansson (2002*)**, who studied social networks of persons with severe mental illness in in-patient settings and supported community settings in Sweden. They found that a greater proportion of them in comparison to the general population, have smaller social networks and a low network density.

The current results revealed that there were statistical significant positive correlations between QOL in relation to social support from significant others, from family, and from friends. Besides, there was a positive correlation between total score of QOL and total score of social support. Many explanations for these findings are possible; as life revolves around close relationships including family, friends, significant others and their existence and support have positive impact on physical and psychological well-being as well as QOL. Social support can reduce the negative effects of stressful life events via the supportive actions of others that enhance coping performance, or through the belief that support is available, which leads to the appraisal of potentially threatening situations as less stressful.

This result was in line with a Pakistani study by ***Yasien, Alvi, and Moghal (2013)***, who studied perceived social support and QOL of psychiatric patients. This study revealed that social support from family, friends and significant others was related with QOL and its subcomponents in patients with mental illness. Similar results were identified by ***Yanos, Rosenfiel , and Horwitz*** **(2001)** in United States. They studied social interactions and QOL among persons diagnosed with severe mental illness and reported that supportive social interactions and frequency of social contact were correlated to higher QOL of persons diagnosed with severe mental illness.

As for the present study, it was noticed that high social support was statistically significant among patients in inpatient departments than outpatient clinics. This may be related to the fact that patients who were in in-patients departments are more stable and can make social contact with doctors, nurses, and other patients as well as their families, relatives, and friends during visiting hours. This is in agreement with ***McCall, Reboussin, and Rapp (2001)***, in United States, who revealed that social support increased in the year after inpatient treatment of psychiatric patients. In addition, ***Browne and Courtney (2004)***, in Australia found that people with severe mental illness living in apartments or community housing had less social support because of social stigma.

The current results illustrated that low social support system was statistically significant among patients who had disease from one year to less than five years. This might be due to the fact that people around psychiatric patients with new diagnosis are unable to understand nature of this disorder and unable to deal with them. In addition, they avoid these patients and reject them because of social stigma that caused by mental illness to patients and their social relationships. This interpretation was supported by ***Ostman and Kjellin (2002),*** who studied stigma association and psychological factors in relatives of people with mental illness, and reported that stigma often carried over to friends and relatives of a person who is mentally ill, which is known as "courtesy" or "associative" stigma leading to disturbance in the patient's relationships.

The results of this study revealed that high social support system was statistically significant among patients who started treatment from one year to less than five years. This might be explained by that patients' social support network may be increased in the first years of treatment as symptoms may be controlled by the treatment. This explanation is supported by ***Brugha, Morgan, Bebbington, Jenkins, Lewis, Farrell, and Meltzer (2003),*** in Britain. They studied social support networks and type of neurotic symptoms, and reported that these symptoms were highly statistically significantly associated with deficient social support.

The result of the present study illustrated that high social support system was statistically significant among patients who had previous hospitalization. This may be because patients who had previous hospitalization had additional social support from doctors, nurses, and other patients. In the same line, ***Holmes-Eber and Stephanie (1990)*** in United States, who studied hospitalization and composition of mental patients' social networks found that previous hospitalizations are related to a larger number and percentage of mental health and other professionals in patients' social networks.

The present study showed that schizophrenic patients had lowest QOL compared to other patients. This may be due to that schizophrenia is a severe mental illness associated with a wide range of symptoms including positive symptoms such as hallucinations, delusions, and a disorganized symptoms and this may have a

significant negative effect on QOL. This result supported by, ***Bechdolf, Klosterkötter, Hambrecht, Knost, Kuntermann, Schiller, and Pukrop (2003)*** in Germany, who studied determinants of subjective QOL in post acute patients with schizophrenia and found that patients with schizophrenia had the lowest QOL than other patients. In contrary, a study in Finland by ***Saarni, Härkänen, Sintonen, Suvisaari, Koskinen, Aromaa, and Lönnqvist (2006)*** examined the impact of chronic conditions on health-related QOL and revealed that depressive and anxiety disorders have a major impact on QOL than psychosis.

CONCLUSION &RECOMMENDATIONS:

Based on the findings of the current study, it can be concluded that most of psychiatric patients have low social support and QOL. In addition, there is a relation between social support and QOL. Therefore, social support should be an essential part of psychiatric treatment because of its important role in enhancing patients' QOL. Also, it was observed that the age, educational level, employment status, disease onset, onset of treatment, and previous hospitalization significantly affect the social support level. However, the age, income, employment status, diagnosis, and disease onset significantly affects the QOL.

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

- Increase awareness of the mental health team about the importance of dealing holistically with psychiatric patients (i.e. considering their physical, psychological, social, and environmental aspects).

- There is a great need to establish programs for families of psychiatric patients to increase their understanding of the nature of psychiatric illness to increase their support for their patients.

- A training program for nurses about the importance of social support to patients and their families during difficult times.

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العلاقه بين المساندة الإجتماعية و جودة الحياة لدي المرضي النفسيين

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الخلاصة

إن اضطرابات الصحة العقلية تؤثر على الأداء اليومي للأفراد، والقدرة على الحفاظ على علاقاتهم الإجتماعية وانخفاض جودة حياتهم. إن لل مساندة الإجتماعية فائدة كبيرة للصحة العقلية، فضلا عن تعزيز جودة الحياة للمريض النفسي. **هدف البحث:** تقييم العلاقة بين المساندة الإجتماعية وجودة الحياة لدي المرضى النفسيين. **طرق وادوات البحث:** أجريت الدراسة الوصفية ذات العلاقات المشتركة علي 115 مريض من المترددين علي خمسة من الأقسام الداخلية والعيادة الخارجية لمستشفي الصحة النفسية ببورسعيد. تم تجميع البيانات عن طريق المقابلة الشخصية لكل مريض باستخدام ثلاثة أدوات وهي استمارة تقييم جودة الحياة، استمارة تقييم المساندة الإجتماعية واستمارة بيانات شخصية واكلينيكية. **النتائج:** معظم المرضى النفسيين يعانون من إنخفاض المساندة الإجتماعية وجودة الحياة. وقد كان أكثر جوانب الحياه تأثرا هو الجانب الإجتماعي. وبالإضافة إلى ذلك، كانت هناك علاقة ذات دلالة إحصائية بين المساندة الإجتماعية وجودة الحياة. وقد لوحظ أن السن ، المستوى التعليمي، الوضع الوظيفي، بداية ظهور أعراض المرض، و بداية العلاج من العوامل التي تؤثر على مستوى المساندة الإجتماعية. في حين أن العمر، الدخل، الوضع الوظيفي، التشخيص، و بداية المرض من العوامل التي تؤثر على جودة الحياة. **الاستنتاجات والتوصيات :** يمكن الاستنتاج أن أكثر من نصف المرضى النفسيين لديهم انخفاض في جودة الحياة وثلثي المرضي لديهم انخفاض في المساندة الإجتماعية. وبالإضافة إلى ذلك، هناك علاقة بين المساندة الإجتماعية وجودة الحياة. لذلك، يجب أن تكون المساندة الإجتماعية جزءا أساسيا من العلاج النفسي بسبب دورها الهام في تعزيز جودة الحياة للمرضى.وقد أوصت الدراسة بزيادة وعي فريق الصحة النفسية حول أهمية التعامل بشكل كلي مع المرضى النفسيين أي النظر إلي الجوانب المادية ، النفسية ، الإجتماعية ، والبيئية للمريض

الكلمات المرشدة : المرض النفسي ،المساندة الإجتماعية، جودة الحياة.