Relationship Between Social Support and the Quality of Life among Psychiatric Patients

Amal Sobhy Mahmoud, Abeer Elsayed Berma, Samar Atiya Abo Saleh Gabal

Psychiatric Nursing and Mental Health, Port Said University, Port Said, Egypt

*Corresponding Author: Amal Sobhy Mahmoud, Egypt- Faculty of Nursing, Port Said University-Port Said-Orabi and El-Etehad Street in front of Shoban ElMoslemeen, Port Said, Egypt, Tel: 00201015304080; E-mail: sunmoonstars25@yahoo.com

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 utilized for the current study. The study subjects were consisted 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 socio demographic and clinical data questionnaire.

Results: The study revealed that, more than half of the psychiatric patients reported low QOL and two third of them reported low social support. In addition, there was 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. While, 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, increase 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: Mental illness; Quality of Life and Social support.

1. Introduction

Mental illness can have devastating effects on the individual and his 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 threaten psychological and emotional well-being, quality of life (QOL), and increased 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 [1].

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) [2].

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 [3].

QOL is an essential area to investigate because of its implications for the well-being of individuals with mental health problems. It is difficult to cure people with mental health illness. Therefore, the objective of interventions includes improving aspects of QOL. Therefore, research in this area could be used to help inform interventions and the development of services. Social support in people with mental health illness is important because of its impact on the well-being and QOL [4].

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 [5]. QOL is a person's sense of well-being, health status and satisfaction with life circumstances, including access to resources and opportunities [6].

There is an Egyptian study was conducted on psychiatric patients and found that, patients with schizophrenia, depression, and obsessive-compulsive disorders are the most patients who suffer from lost interest in the functions of everyday life , disruption of thought, and weakness all these factors lead to non enjoyment of everyday life and low QOL [7].

1.1 Significance of this study

Mental ill patients found difficulty in social support and QOL. So that, 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.

2.   Aim of Study

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

2.1 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.

3. Subjects and Method

3.1 Research design

A descriptive correlational research design was followed in this study.

3.2 Study setting

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

3.3 Study subjects

A convenience sample with total number of 115 psychotic patients and three patients dropped out, attending the psychiatric outpatient clinic and five inpatient units in the previously mentioned hospital. From both sexes age ranged from 20-65 years old. (The total sample size amounted to 118 patients).

3.4 Sample size

To achieve the study objective, the sample size was determined by using the following equation. The sample size was determined by using the following equation [8]:

Sample size (n) = (z /Δ) 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 % [9]. Zα/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 was =118 patients.

3.5 Tools of data collection

3.5.1 TOOL I: WHO Quality of Life Scale (Bref version) (WHOQOL – Bref): The WHOQOL – Bref developed by World Health Organization [10] and translated into Arabic by Ahmed [11]. 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 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% [12].

3.5.2 TOOL II: The Multidimensional Scale of Perceived Social Support (MSPSS): This questionnaire was developed by Zimet et al. [13], and translated by Abou Hashem [14]. 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.

3.6 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.

3.7 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).

- A written formal consent was obtained from each selected patient for participation in the study after explaining the aim of the study, establishing rapport, and trusting relationship with the studied patient.
- The tools were filled by the researcher using the interview method on an individual basis.
- Each interview lasted for about from 60-90 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.

4. 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.

4.1 Ethical Considerations

A written consent was taken from patients, 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.

4.2 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.

5. Results

Table (1) reveals that patients' age ranges between 20-65 years with a mean age ± SD of 34.1 ± 12.0 years, more than half of them (53.9%) their age ranges between 20-35 years old, 61.7% were males, and 59.1% of them were single, 40% of them have secondary education, while, only 14.0% of patients are illiterate/read and write. More than three quarter (87.8%) of the studied patients were unemployed. While, 80% of them were employed as a manual worker, compared to 20.0% were employee, 55.7% have enough income, 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 + 5.3 years and about 53.0% had 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 third 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. While, 40.9% of them had high score toward physical domain. Three quarter 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 a 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. In addition, 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 MCP<0.0001.

Table (6) illustrates that, 59.5% of schizophrenic patients have the lowest level of quality of life compared to other patients. In addition 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	16	14.0
Illiterate/ Read and write		
Basic education	39	33.9
Secondary education	46	40.0
	14	12.1
University education or higher		
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**

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			Score (%)			
	Min-Max	Mean ± SD	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 $P \leq 0.05$

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	
Bipolar disorder	15	21.7	14	30.5	X^2=6.558
Depression	8	11.6	0	0.0	[MC]P=0.162
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	
10-<15	8	11.6	10	21.7	P=0.018*
15-20	4	5.8	9	19.6	
Onset of Treatment (years)					
Not started treatment yet	18	26.1	0	0.0	
1-<5	29	42.0	25	54.3	X^2=20.795
5-<10	11	15.9	4	8.7	^{MC}P<0.0001*
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	X^2=4.92
5-<10	21	24.1	2	7.1	
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

6. Discussion

Psychotic disorders are often chronic, lifelong illnesses that have a major impact on the individual, family, and community resources [15]. People with mental illness struggle with poor QOL and social support, they often cannot develop or sustain supportive relationships within their lives [16].

Social support is widely recognized as a crucial factor for mental health and wellbeing (Ng C et al [17]. It is one of the most effective means by which people can cope with and adjust to difficult and stressful events [18] and has a positive effect on the process and outcome of psychotherapy and psychiatric treatment [19]. 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 et al. [20], 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 [21], 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 related to that, mental illness affects cognitive, affective, and behavioral status of patients rather than their physical status. This result was supported by an England study, as Blenkirson & Hammille [22] 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 et al. [23] 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 explained by 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 et al. [24] 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 et al. [25], in United States 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 [26] who studied social networks of persons with severe mental illness in in-patient settings and supported community settings in Sweden and 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 related 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 it being all around. It is a disgrace being a mentally ill patient, or associated to someone who is. This result contradicted with, Sharir [27], in United States who 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 [26], who studied social networks of persons with severe mental illness in in-patient settings and supported community settings in Sweden and 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. In addition, 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 include 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 et al. [9] who studied perceived social support and QOL of psychiatric patients and 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 et al. [28] in United States who 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.

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 explained by 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 et al. [29] in United States who revealed that, social support increased in the year after inpatient treatment of psychiatric patients. In addition, Browne and Courtney [30], in Australia found that, people with severe mental illness living in apartments or community housing had less social support because of social stigma.

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 et al. [31], 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 from Finland by Saarni et al. [32] who studied the impact of chronic conditions on health-related QOL and revealed that, depressive and anxiety disorders have a major impact on QOL than psychosis.

7. Conclusion and 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. While, 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.

References

1. Pernice-Duca F. The relationship between social network supports and recovery from mental illness. Unpublished Doctoral Dissertation, Michigan State University. United States (2005): 22-39.

2. Osman F. Factors leading to feeling of loneliness among hospitalized mentally ill patients. Unpublished Master Thesis, Faculty of Nursing, Tanta University. Egypt (2014): 5-16.

3. Pasmeny G. Social support and quality of life in adults with severe and persistent mental illness. Unpublished Master Thesis, School of Graduate Studies, University of Lethbridge. Canada (2009): 14-30.

4. Hartfield C. What mediates quality of life for the severely and persistently, mentally ill? Unpublished Doctoral Dissertation, Faculty of the Graduate School, Hahnemann University. United States (2000): 5-20.

5. Evans S, Banerjee S, et al. The impact of mental illness on quality of life: A comparison of severe mental illness, common mental disorder and healthy population samples. Quality of Life Research 16(2007): 17-29.

6. Medici C, Vestergaard C, et al. Quality of life and clinical characteristics in a non-selected sample of patients with schizophrenia. International Journal of Social Psychiatry 62(2016): 12-20.

7. Essawy H, Saad A, et al. Assessment of the quality of life in chronic psychiatric Egyptian patients. Journal of Current Psychiatry 7(2000): 71-84.

8. Naing N. Determination of sample size. The Malaysian Journal of Medical Sciences 10(2003): 84-86.

9. Yasien S, Alvi T, et al. Does perceived social support predict quality of life in psychiatric patients? Asian Journal of Social Sciences & Humanities 2(2013): 32-41.

10. World Health Organization Quality of Life Group (WHOQOL). Development of the World Health Organization WHOQOL-BREF quality of life assessment. Psychological Medicine 28(1998): 551-558.

11. Ahmed B. WHO Quality of life bref scale. Anglo library, Cairo, Egypt (2008).

12. Silva P, Soares S, et al. Cut-off point for WHOQOL-bref as a measure of quality of life of older adults. Revista de saude publica 48(2014): 390-397.

13. Zimet G, Dahlem N, et al. The multidimensional scale of perceived social support. Journal of Personality Assessment 52(1988): 30-41.

14. Abou Hashem E. Structure model relations between psychological well- being and big five personality factors and self-esteem and social support to university students. Journal of the Faculty of Education, Banha University 20(2010): 269- 50.

15. Capleton R. Awareness of illness in psychotic disorders: A treatment intervention to increase illness awareness, improve quality of life, and prevent recidivism in psychiatric patients. Unpublished Doctoral Dissertation. The Faculty of the Doctorate of Psychology Program, Regent University, Virginia. United States (2000): 10-18.

16. Mordoch E. Finding the rhythm, maintaining the frame: how children manage living with a parent with a mental illness. Unpublished Doctoral Dissertation, The Faculty of Graduate Studies, University of British Columbia. Canada (2005): 5-12.

17. Ng C, Nurasikin M, et al. Factorial validation of the Malay version of multidimensional scale of perceived social support among a group of psychiatric patients. Malaysian Journal of Psychiatry 21(2012): 35-50.

18. Kim H, Sherman D, et al. Culture and social support. American Psychologist 63(2008): 518-533.

19. Brüggemann B, Garlipp P, et al. Quality of life and social support as outcome characteristics of a psychiatric day hospital. German Journal of Psychiatry 10(2007): 58-68.

20. Langeland E, Wahl A, et al. Quality of life among Norwegians with chronic mental health problems living in the community versus the general population. Community Mental Health Journal 43(2007): 321-339.

21. Young K. Positive effects of spirituality on quality of life for people with severe mental illness. International Journal of Psychosocial Rehabilitation 16(2012): 62-77.

22. Blenkirson P, Hammill C. What determines patients' satisfaction with their mental health care and quality of life? Postgraduate Medical Journal 79(2003): 337-340.

23. Nyboe L, Lund H. Low levels of physical activity in patients with severe mental illness. Nordic Journal of Psychiatry 67(2012): 43-46.

24. Bronowski P. and Załuska M. Social support of chronically mentally ill patients. Archives of Psychiatry and Psychotherapy 2(2008): 13-19.

25. Goldberg R, Rollins A, et al. Social network correlates among people with psychiatric disabilities. Psychiatric Rehabilitation Journal 26(2003): 393- 404.

26. Brunt D, Hansson L. The social networks of persons with severe mental illness in in-patient settings and supported community settings. Journal of Mental Health 11(2002): 611-621.

27. Sharir D. Social support and quality of life among psychiatric patients in residential homes. Unpublished Doctoral Dissertation, Faculty of the College of Health Sciences, Touro University International. United States (2005): 5-30.

28. Yanos P, Rosenfield S, et al. Negative and supportive social interactions and quality of life among persons diagnosed with severe mental illness. Community Mental Health Journal 37(2001): 405-420.

29. McCall W, Reboussin B, et al. Social support increases in the year after inpatient treatment of depression. Journal of Psychiatric Research 35(2001): 105-110.

30. Browne G. and Courtney M. Measuring the impact of housing on people with schizophrenia. Nursing and Health Science 6(2004): 37-44.

31. Bechdolf A, Klosterkötter J, et al. Determinants of subjective quality of life in post acute patients with schizophrenia. European Archive of Psychiatry and Clinical Neuroscience 253(2003): 228-235.

32. Saarni S, Härkänen T, et al. The impact of chronic conditions on health-related quality of life: A general population survey in Finland. Quality of Life Research 15(2006): 1403-1414.